In the Supreme Court of the United States

October Term, 1979

No. 79-878

WESTMORELAND HOSPITAL ASSOCIATION, a non-profit corporation, LATROBE AREA HOSPITAL, a non-profit corporation, THE ALTOONA HOSPITAL, a non-profit corporation, THE HAMOT MEDICAL CENTER OF ERIE, PENNSYLVANIA, a non-profit corporation, MEADVILLE CITY HOSPITAL, a non-profit corporation, SAINT VINCENT HEALTH CENTER, a non-profit corporation, COMMUNITY MENTAL HEALTH CENTER OF BEAVER COUNTY, a non-profit corporation, SOUTH HILLS HEALTH SYSTEM, a non-profit corporation, and HENRY CLAY FRICK COMMUNITY HOSPITAL, a non-profit corporation,

Plaintiffs-Petitioners,

v.

BLUE CROSS OF WESTERN PENNSYLVANIA, a non-profit corporation,

Defendant-Respondent.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

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[1975] U.S. Code Cong. & Ad. News 7
House Report [Interstate and Foreign Commerce Committee], No. 94-192, May 7, 1975—to Accompany H.R. 4925 6

The Petitioners pray that a Writ of Certiorari issue to review the Judgment Order of the United States Court of Appeals for the Third Circuit entered September 10, 1979.

OPINIONS BELOW

The Opinion of the Court of Appeals, reported at 605 F.2d 119 (3d Cir. 1979), appears in the Appendix hereto (App. D, *infra*). The Opinion rendered by the United States District Court for the Western District of Pennsylvania is unreported, appears in the Appendix hereto (App. F, *infra*).

JURISDICTION

The judgment of the Court of Appeals for the Third Circuit was entered September 10, 1979. No petition for rehearing was filed by petitioners. This Court's jurisdiction is invoked under 28 U.S.C. §1254(1).

QUESTION PRESENTED

Whether the federal statute and public policy pertaining to staffing grants awarded to initiate Community Mental Health Centers prohibit any contract term, arrangement or custom and practice between Community Mental Health Centers and private health insurers, whereby the private health insurer lessens its obligations to the CMHC's and receives a substantial benefit from the grant money to the detriment of the mental health program.

STATUTE INVOLVED

42 U.S.C. §2661 *et seq.*, as amended, particularly, §2689 *et seq.*, providing for financial assistance to initiate "Community Mental Health Centers" (CMHC's). In more particular, 42 U.S.C. §2688a(4), providing that staffing grants to initiate CMHC's will not be used to "supplant" or lessen amounts which would otherwise be received by CMHC's from insurance companies. 42 U.S.C. §2688a(4) is set forth in Appendix B, *infra*, p. 3a. 42 U.S.C. §2688 is set forth in Appendix A, *infra*, p. 1a.

STATEMENT OF THE CASE

This is a case of first impression under the federal statutes pertaining to the award of staffing grants to initiate services to the mentally ill by Community Mental Health Centers.

Finding a solution to the problem of providing care for those suffering from mental illness in the United States has been a difficult task. It has been stated that one out of every ten persons will need psychiatric help at some time in their life and, further, that nearly every year 1,500,000 receive treatment in institutions for the mentally ill and mentally retarded.

Mental illness may occur at any age and overwhelming numbers of those persons affected with mental illness are and have been without the financial means to obtain proper care and treatment; hence, of necessity, they have been forced to accept whatever public services are offered. Historically, prior to involvement of the federal government, the situation with regard to the care and treatment of the mentally ill in state institutions was pitiful.

And, with regard to state institutions, on February 3, 1963, President Kennedy in submitting to Congress a special message on "Mental Illness and Mental Retardation," stated the following as illustrative of such institutions:

> "Nearly one-fifth of the 279 State mental institutions are fire and health hazards; three-fourths of them were opened prior to World War I.
>
> Nearly half of the 530,000 patients in our State mental hospitals are in institutions with over 3,000 patients, where individual care and consideration are almost impossible.
>
> Many of these institutions have less than half the professional staff required—with less than 1 psychiatrist for every 360 patients.

> Forty-five percent of their inmates have been hospitalized continuously for 10 years or more."

([1963] U.S. Code Cong. & Ad. News, p. 1466, 1468-69.)

President Kennedy also stated:

> "It is my intention to send shortly to the Congress a message pertaining to this Nation's most urgent needs in the area of health improvement. But two health problems—because they are of such critical size and tragic impact, and because their susceptibility to public action is so much greater than the attention they have received—are deserving of a wholly new national approach and a separate message to the Congress. These twin problems are mental illness and mental retardation.
>
> From the earliest days of the Public Health Service to the latest research of the National Institutes of Health, the Federal Government has recognized its responsibilities to assist, stimulate, and channel public energies in attacking health problems. Infectious epidemics are now largely under control. Most of the major diseases of the body are beginning to give ground in man's increasing struggle to find their cause and cure. But the public understanding, treatment, and prevention of mental disabilities have not made comparable progress since the earliest days of modern history.
>
> Yet mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the Public Treasury and the personal finances of the individual families than any other single condition."

(*Id.* at pp. 1466-67.)

* * *

"Central to a new mental health program is comprehensive community care. Merely pouring Federal funds into a continuation of the outmoded type of institutional care which now prevails would make little difference. We need a new type of health facility, one which will return mental health care to the main stream of American medicine, and at the same time upgrade mental health services. I recommend, therefore, that the Congress (1) authorize grants to the States for the construction of comprehensive community mental health centers, beginning in fiscal year 1965, with the Federal Government providing 45 to 75 percent of the project cost; (2) authorize short-term project grants for the initial staffing costs of comprehensive community mental health centers, with the Federal Government providing up to 75 percent of the cost in the early months, on a gradually declining basis, terminating such support for a project within slightly over 4 years; and (3) to facilitate the preparation of community plans for these new facilities as a necessary preliminary to any construction or staffing assistance, appropriate $4.2 million for planning grants under the National Institute of Mental Health. These planning funds, which would be in addition to a similar amount appropriated for fiscal year 1963, have been included in my proposed 1964 budget."

(*Id.* at p. 1469.)

In response to President Kennedy's message, the United States Congress in 1963 first enacted legislation providing for financial assistance to "Community Mental Health Centers," 42 U.S.C. §2661 *et seq.*, as amended.[1] The initial legislation generally provided funds for new buildings facilities. That legislation was amended several times and, subsequent to the 1975 amendments, the relevant provisions are now found at 42 U.S.C. §2689 *et seq.*

[1][1963] *U.S. Code Cong. & Ad. News*, pp. 1054, 1063 and [1965] *U.S. Code Cong. & Ad. News*, pp. 2401, 2402 are informative as to the background of the legislation pertaining to the construction and staffing of CMHC's.

The object of the entire body of legislation was to sponsor, through grants, the creation of a national system of local mental health centers to provide the greatly needed and long-overdue facilities at the local level for those persons in need of mental health care. It was intended that after initial aid from the federal government the responsibility would shift to the states, localities, and the medical profession. To spur this social welfare program, Congress authorized that grants be made to hospitals which would undertake the task to establish and provide a specified mental health care program. One of the various grants, and that central to this dispute, is designated as the "Mental Health Staffing Grant."

The extent of a mental health staffing grant is measured by a percentage of the total projected expense for wages and salaries for professional and technical employees to staff the centers. The top percentage varies from 90% in poverty areas to 75% in nonpoverty areas. The grant extends for a maximum of eight years generally at a declining rate each year. The grants defray what may be characterized as the heavy startup costs for the program, thus insuring their successful operation until the Centers can find other means of financing their operations through states, localities and insurance companies. Staffing grants came to be specifically designated as "seed money" grants as an expression of the concept, object and purpose of the legislation (App. C, p. 7a.).

As a requisite for obtaining grants, each prospective CMHC is required to assure the Department of Health, Education and Welfare[2] (HEW), the agency in charge of authorizing and supervising the grants, that staffing grants will not be used to "supplant" or lessen amounts which would otherwise be received by the hospitals from insurance

[2]Now the Department of Health and Human Services. (Department of Education Organization Act, P.L. 96-88 §101 *et seq.*, 93 Stat. 668 (1979)).

companies or other third-party payors. (App. B, p. 3a.) In particular, the Secretary of HEW must have sufficient assurance from the prospective recipient that "Federal funds made available under this part for any period will be so used as to supplement and, to the extent practicable, increase the level of State, local and other non-Federal funds, including third-party health insurance payments, that would in the absence of such Federal funds be made available to the program . . . and will in no event supplant such State, local or other non-Federal funds. . . ." 42 U.S.C. §2688a(4), (App. B, p. 4a)

The import of the above requirements is simply that to acquire federal staffing grants, each applicant must assure the Secretary that these funds will supplement other income and will not be used as a substitute for or to lessen monies that, in the absence of the federal grant, would be available to the recipient.

The above noted legislation has been amended by P.L. 94-63, 42 U.S.C. §2689. The legislative history of these amendments is illuminatory regarding Congressional intent in the entire staffing grant program. For example, the House of Representatives Committee Report (House Report [Interstate and Foreign Commerce Committee] No. 94-192, May 7, 1975—To accompany H.R. 4925) states the following (at p. 120):

> "The Committee emphasizes that CMHC's are entitled to collect from all third party payors the full fee or payment for services (to the extent such service is covered under the insurance policy or assistance program). The Committee is disturbed by reports that some private insurance companies do not reimburse CMHC's for the full cost of providing services on the basis that the CMHC Act requires centers to provide services to all in need, regardless of ability to pay. *It is not the Committee's intent that the CMHC grant program subsidize private health insurance; and under the*

> *terms of these amendments (subparagraph (k) above) this is expressly prohibited.*" (Emphasis added.)

Again, in the Senate Report on this legislation #94-29, it is stated ([1975] Code Cong. & Ad. News, p. 552):

> "In collecting from private insurance sources, the Committee expects that centers will bill the insurers the full amount of the established fees. Currently many centers are having difficulty obtaining full payment from insurance companies because of their statutory obligation to provide services regardless of ability to pay. The Committee wishes to emphasize that *the CMHC Act was not* intended to subsidize private health insurance [and] the Committee expects insurance companies to reimburse for the reasonable charge (up to the limits of the fee schedule in the policy) of services rendered in the CMHC." (Emphasis added.)

The Federal Department of Health, Education and Welfare has expressed its opinion on the purpose of this legislation. In a letter[3], HEW stated the following:

> "We recently received an opinion on this question from the Office of General Counsel. . . Their interpretation is that NIMH Staffing Funds should be considered 'unrestricted', and that they are supplementary rather than a substitution for any and all other funds. Their interpretation is based on an interpretation of Public Law 89-105, the legislative history, and the Regulations promulgated under this law. It is the opinion of General Counsel that if NIMH Staffing Funds are being used to reduce non-federal expenditures they are being misused."

Of the approximately 100 hospitals located in Western Pennsylvania under contract with respondent Blue Cross of Western Pennsylvania ("Blue Cross"), only the 10-petitioner-hospitals undertook the task and challenge to improve the

[3]Exhibit "A" to Petitioner's original complaint, admitted into evidence at trial as PX-204.

situation for the mentally ill by providing the facilities and services required by the program. The mandated services provided by the hospitals are as follows:

1. In-patient
2. Out-patient
3. Emergency
4. Partial hospitalization
5. Consultation and education
6. Children's services
7. Elderly services
8. Mental retardation services
9. Drug and alcohol abuse where no such program exists

The total of staffing grants allotted to all petitioner-hospitals, both paid already and forecast for the future, is approximately $28,000,000. To obtain the grants, the hospitals gave assurances to HEW that the grants would not be used to lessen benefits from others, such as insurance companies. However, promptly after South Hills Health System, the first hospital in point of time to receive its grant from HEW, received the approximate sum of $141,000 from HEW in 1970, Blue Cross laid claim to a share. Blue Cross contended that since the grants to the hospitals were "restricted" to personnel costs Blue Cross was entitled to offset the hospitals' actual costs by the grant income in determining reimbursement to the hospital for services to Blue Cross subscribers; hence, Blue Cross decreased its payments to SHHS in the first year by the sum of $61,000.[4] Thereafter, as each hospital received its grant, Blue Cross by an accounting

[4]Unlike the typical private insurance company which contracts only with its policyholders and pays the hospitals or insureds the full amount of hospital "charges" to the patient within the limits of coverage, Blue Cross, by virtue of "cost reimbursement" contracts with the hospitals, receives more favorable terms than others and in the end usually pays the hospitals significantly less for the same services than either uninsured patients or other private insurers. In essence, Blue Cross obtains a discount price for health care of approximately 15 to 20 percent.

methodology lessened its liability to the hospital. On the average, Blue Cross deprived the hospitals and the mentally ill of approximately 25 percent of the grants—or $7,000,000—but, in one case, that of SHHS, out of grants of approximately $2,356,000, Blue Cross gained $1,004,000!

The hospitals steadfastly refused to recognize any right on the part of Blue Cross to lessen its contractual obligations to the hospitals and benefit from the grants, but the hospitals were unable to stop the Blue Cross practice.[5]

HEW agreed with the position of the hospitals and advised Blue Cross that its treatment of the grants was improper. In fact, as early as 1969, HEW had directed Blue Cross in its role as HEW's Medicare Intermediary in Western Pennsylvania that, although the grants were for staffing costs, the grants were to be treated as "unrestricted" and not to be offset against the hospitals' actual costs. Blue Cross followed HEW's direction with regard to Medicare payments that the grants were "unrestricted" to the hospitals and not to be offset against costs for purposes of Medicare payments, but refused to accept HEW's determination and direction with regard to Blue Cross's contractual obligations to the hospitals for the care and treatment of Blue Cross subscribers.[6]

Finally, HEW, which had no power to deal directly with Blue Cross with regard to its contractual relationship with

[5]Because of Blue Cross's dominance in the health insurance business and the insignificance of only 10 of the 100 hospitals contracting with Blue Cross in Western Pennsylvania and the penalties imposed on a Blue Cross subscriber should he go to a non-contracting hospital, economic necessity and hardship on the community have compelled the hospitals to continue the contractual relationship with Blue Cross. On one occasion, years ago, Altoona Hospital severed the relationship, but it was quickly forced back into the ranks.

[6]Blue Cross acknowledges that in accordance with past practice when grants are identified as "unrestricted" by a grantor, the income is not to be offset against costs.

the hospitals for services to Blue Cross subscribers, threatened the hospitals that the grants would be stopped if the practice continued; thus, the hospitals and communities were faced with a shutdown of the facilities. As later expressed by the Court of Appeals for the Third Circuit (App. D, p. 10a.): "... Thus, to use the current idiom, the appellant hospitals found themselves between a rock and a hard place ..."

This case concerns whether the judiciary will permit the intended benefit of federal staffing grants to CMHC's to be lessened and a substantial portion go to the benefit of private health insurers and consequently injure the petitioner-hospitals and the public, particularly the mentally ill. An affirmance of the judgment below would—put bluntly—deprive the hospitals of approximately 25 percent of the staffing grant benefits; deprive the unrepresented mentally ill of Western Pennsylvania of the services and benefits they have a right to expect; and, establish an important question of federal law adverse to the mental health program throughout the United States by recognizing and approving a right of private health insurers to lessen their liability to CMHC's by reason of the federal staffing grants.

PROCEEDINGS BELOW

Unable to solve the impasse by means of negotiations, the hospitals on October 20, 1976, commenced an action against Blue Cross in the Court of Common Pleas of Westmoreland County, Pennsylvania. For the reason that the hospitals believed they had no claim against HEW or basis to bring suit in a federal district court and, because Blue Cross was not directly involved with HEW and the grants, the hospitals sued in the state court for breach of contracts by Blue Cross and for injunctive relief to prevent the deduction of the staffing grants.

The hospitals' complaint set forth the background to the dispute, including a detailed recitation of facts concerning the federal grants and Blue Cross's position with regard thereto. Blue Cross removed the case to the United States District Court for the Western District of Pennsylvania on the basis of a federal question and, after removal, the District Court on its own motion joined HEW as an indispensable party and entered a temporary restraining order enjoining Blue Cross from deducting the staffing grants. HEW continued the grants and the facilities continued in operation. The District Court denied the hospitals' motion to remand to the state court and HEW counterclaimed against eight of the hospitals to recover approximately $4,000,000 for allegedly erroneous grant payments after 1975 based upon misuse of the grants by the hospitals for reason of Blue Cross's practice.

A lengthy bench trial was held ending in August 1977. As to the merits, the hospitals contended that the contracts with Blue Cross contained no terms or provisions by which Blue Cross could reduce its liability to the hospitals because of the grants but that in any event a contract term, or custom and practice, so providing would be void or unenforceable as contrary to the federal statute and public policy, both that of Pennsylvania and of the United States. It was further contended by the hospitals that not only was the case important to them, it was of critical importance to that unrepresented group of society whose civil rights guaranteed opportunities for mental health care which would be adversely affected by Blue Cross's practice.

On August 14, 1978, without so much as citing a single Pennsylvania authority to support its conclusion (as, indeed, it could not), the District Court decided the issue on a contracts basis and in substance concluded that by custom and practice Blue Cross could obtain the benefit of the federal

staffing grants and such was not against the federal statute or public policy.[7] The District Court, relying upon *ETS-Hokin & Galvan, Inc. v. Maas Transport, Inc.*, 308 F.2d 258 (8th Cir. 1967) (App. F, p. 32a.), held that:

> "[T]he legislation did not expressly deal with the Blue Cross practice or make it illegal by clear and precise words."

The District Court went on to state: (App. F, p. 32a)

> "We refuse to find the Blue Cross contracts illegal or opposed to public policy. None of the Amendments in plain language made the practice, which was part of the contracts, illegal or opposed to public policy. . . ."

The District Court recognized that Blue Cross benefited by deducting the grants (App. F, p. 34a), but believed that as the hospitals' costs to run mental health out-patient departments exceeded charges to patients, Blue Cross was required by its contract to pay the hospitals more than it would have if there had been no mental health operations or charges to

[7]An abundance of Pennsylvania authorities support the hospitals' contention that no contract term for the offsetting of "restricted" grants existed by custom and practice and, further, the evidence established beyond dispute that prior to the federal staffing grants any sums of money hospitals permitted to be offset were *de minimis* and immaterial to establish such right as to the enormous staffing grants. Under Pennsylvania law, custom and practice may be considered for only two reasons: (1) to ascertain the intent of the contracting parties in entering into a contract; and (2) to establish that a contract entered into has been modified.

As to the first reason, see *Plymouth Life Insurance Co. v. Illinois Mid-Continent Life Insurance Company of Chicago, Inc.*, 378 F.2d 389 (3d Cir. 1967). But, the alleged conduct must be harmonious, uniform and free from ambiguity. *In re Baker's Trust Estate*, 333 Pa. 273 (1939). As to the second reason, a new consideration must flow between the parties for a practice to become a part of the contractual relationship. See *Nicoleloa v. Palmer*, 432 Pa. 502, 248 A.2d 20 (1968) and *Pellegrini v. Luther*, 403 Pa. 212, 169 A.2d 298 (1961).

patients were higher; thus, the District Court concluded Blue Cross's gain from deducting the grants was lessened.[8]

The District Court decided that the grants to the hospitals should continue and further ruled against HEW on its counterclaim to recover the approximately $4,000,000 from the hospitals.

The hospitals and HEW appealed to the United States Court of Appeals for the Third Circuit but shortly thereafter HEW dismissed its appeal to recover damages from the hospitals. The hospitals argued that the case was improperly removed and that, while the construction and interpretation of a federal statute was involved, it was not central to the hospitals' basic cause of action for breach of contracts and the federal issue was properly for the state court to decide incidental to the underlying contracts issue. The Court of Appeals concluded federal jurisdiction[9] was proper and without hearing argument on the merits[10] affirmed the judgment of the District Court relying upon its opinion without further analysis of the federal or public policy issues (App. D; p. 17a.).

REASONS FOR GRANTING THE WRIT

1. In light of the critical need in the United States to have a viable program for those suffering from mental illness and the clear expression of that intent by President Kennedy and

[8]Testimony established that typically, hospitals' out-patient departments and even some other departments are operated at a loss which must be made up from income to other departments. The hospitals' contracts with Blue Cross set ceilings to limit Blue Cross's liability and despite any loss in out-patient departments and spreading of costs to other departments, Blue Cross continued to pay at least 15-20 percent less for services than other insurers or private payors; hence, Blue Cross lost no part of its bargain.

[9]The correctness of this holding is also disputed.

[10]The Court heard oral argument but limited to the issue of federal jurisdiction. At the request of Blue Cross, the Court granted time to file supplemental briefs but, before that could be accomplished by either party, the Court filed its decision as to all issues.

in the legislation that staffing grants should *supplement* income to hospitals and *not lessen* the liability of insurance companies, any contract, arrangement or custom and practice to circumvent and dilute the object of the grants should receive the most careful scrutiny. Here, on the average, petitioner-hospitals stand to lose 25 percent of the benefit of the grants to respondent Blue Cross and this obviously is not *de minimis* and is a very significant loss to the public as well. If the Court does not grant review, the harm to petitioners and the unrepresented public in Western Pennsylvania, particularly the mentally ill, simply cannot be undone, as the intended benefits will be forever lost.

2. The District Court in relying upon *ETS-Hokin & Galvan, Inc. v. Maas Transport, Inc., supra,* applied too restrictive a concept of when a statute or public policy will void a term or provision of a contract (p. 12, *supra*). Commendation of the Blue Cross practice *in ipsis verbis* in the legislation or by the Secretary of HEW surely cannot be required as the District Court concluded. If so, to protect the grants and grantees, Congress and/or the Secretary of HEW would be required to perceive each and every possible contract term, arrangement or custom and practice—here, an insurer's cost reimbursement methodology—which would undermine and undo the purpose and objects of the legislation. For the judiciary to require such perception on the part of Congress is not only unrealistic, it is totally unwarranted when the general intent of the legislation is clear.

3. The decision on the merits by the District Court affirmed by the Court of Appeals for the Third Circuit is a case of first impression with far-flung consequences. The decision impacts adversely on CMHCs and the unrepresented public, particularly the mentally ill, for whom the legislation was enacted and intended to benefit. Blue Cross plans exist throughout the United States and all CMHC's

throughout the nation can be adversely affected. The decision of this Court at the earliest opportunity on the narrow issue raised would be highly desirable for the guidance of all CMHC's and Blue Cross plans, and the issue will not likely be different by reason of other factual situations since the narrow issue raised concerns the construction and/or interpretation of the federal statute and public policy with regard thereto.

4. This Court, in *Steele v. Drummond* 275 U.S. 199, 48 S.Ct. 53, 72 L.ed. 238 (1927), made it clear that there are no fixed rules by which to determine what public policy may be in a given case and when it will render a contract term void; and, since then, though the result has been distinguished in *Muschany v. United States*, 324 U.S. 49, 65 S.Ct. 442, 89 L.ed. 744 (1945), this Court has not departed from its prior statement of the law[11]. Pursuant to the principle, public policy obviously may be drawn from an expression of general intent of the legislative objectives compared to the accused conduct and does not require "clear and precise" words of prohibition as the District Court held. The District Court, and the Court of Appeals for the Third Circuit in affirming the District Court, committed fundamental error in a distortion of when public policy will void a prior contract practice.

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[11]Possibly a Michigan case states the principle most wisely: *(Sipes v. McGhee*, 316 Mich. 614, 25 N.W.2d 638, 642 (1947), *rev'd. on other gds.* 334 U.S. 1 (1948)):

> "'Sometimes such public policy is declared by Constitution; sometime by statute; sometimes by judicial decision. More often, however, it abides only in the customs and conventions of the people—in their clear consciousness and conviction of what is naturally and inherently just and right between man and man. It regards the primary principles of equity and justice and is sometimes expressed under the title of social and industrial justice, as it is conceived by our body politic. . . . Public policy is the cornerstone—the foundation—of all Constitutions, statutes, and judicial decision; and its latitude and longitude, its heighth and its depth, greater than any or all of them.'"

5. A further compelling reason for granting *certiorari* is that the District Court by limiting its inquiry to a search for "clear and precise" words of prohibition or "plain language" prohibiting the Blue Cross practice ignored the clearly expressed general intent of the legislation and that the accused conduct was hostile to that intent. Specifically, the Court failed to consider that there is an obvious hinderance and detriment to the hospitals and the public good by substantial dilution of the staffing grants. The very object of the legislation is being thwarted. Those most in need of medical care and treatment are deprived of their rights. Taxpayers' dollars are diverted from the hospitals to a private insurer. Blue Cross has given no consideration to the hospitals to warrant a further lessening of its liability to pay for services to its subscribers. Further, Blue Cross would not lose the benefit of its original contractual objective of obtaining a 15-20 percent discount for services to its subscribers.

6. Finally, this court should accept jurisdiction if for no other reason than to declare that where taxpayers' dollars are expended for public health purposes, any practice, scheme or device to divert any part of the benefits intended from that goal is against public policy and illegal. The unrepresented mentally ill have no remedy at their disposal to see that the full measure of the intended benefits is available to them. The result frustrates the very purpose of the legislation and is unconscionable.

CONCLUSION

The decision below adversely affects not only petitioner-hospitals, but the unrepresented public in Western Pennsylvania, particularly the mentally ill, and represents a significant setback to the country's commitment to them as expressed by President Kennedy and Congress. The petition for a Writ of Certiotari should be granted.

Respectfully submitted,

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APPENDIX A

PART B.—GRANTS FOR INITIAL COST OF PROFESSIONAL AND TECHNICAL PERSONNEL OF CENTERS

§ 2688. Authorization, duration and amount of grants—Grants to meet portion of costs of compensation of professional and technical personnel

(a) For the purpose of assisting in the establishment and initial operation of community mental health centers providing all or part of a comprehensive community mental health program, the Secretary may, in accordance with the provisions of this part, make grants to meet, for the temporary periods specified in this section, a portion of the costs (determined pursuant to regulations under section 2688c of this title) of compensation of professional and technical personnel for the initial operation of new community mental health centers or of new services in community mental health centers.

Term of grants; maximum amounts

(b)(1) Grants under this section for such costs for any center may be made only for the period beginning with the first day of the first month for which such a grant is made and ending with the close of eight years after such first day; and,

except as provided in paragraph (2), such grants with respect to any center may not exceed 75 per centum of such costs for each of the first two years after such first day, 60 per centum of such costs for the third year after such first day, 45 per centum of such costs for the fourth year after such first day, and 30 per centum of such costs for each of the next four years after such first day.

(2) In the case of any such center providing services for persons in an area designated by the Secretary as an urban or rural poverty area, grants under this section for such costs for any such center may not exceed 90 per centum of such costs for each of the first two years after such first day, 80 per centum of such costs for the third year after such first day, 75 per centum of such costs for the fourth and fifth years after such first day, and 70 per centum of such costs for each of the next three years after such first day.

Matters considered in making grants

(c) In making such grants, the Secretary shall take into account the relative needs of the several States for community mental health center programs, their relative financial needs, and their populations.

Pub.L. 88-164, Title II, § 220, as added Pub.L. 89-105, § 2(b), Aug. 4, 1965, 79 Stat. 428, and amended Pub.L. 91-211, Title II, § 201(a), Mar. 13, 1970, 84 Stat. 56.

APPENDIX B

§ 2688a. Applications and conditions for approval—Necessity of application; conditions precedent to making grant

(a) Grants under this part with respect to any community mental health center may be made only upon application, and only if—

(1) the applicant is a public or nonprofit private agency or organization which owns or operates the center;

(2) the services to be provided by the center, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, will be part of a program providing, principally for persons residing in a particular community or communities in or near which such center is situated, at least those essential elements of comprehensive mental health services which are prescribed by the Secretary;

(3)(A) a grant was made under part A of this subchapter to assist in financing the construction of the center or (B) the type of service to be provided as part of such program with the aid of a grant under this part was not previously being provided by the center with respect to which such application is made;

(4) the Secretary determines that there is satisfactory assurance that (A) the services to be provided will constitute an addition to, or a significant improvement

in quality (as determined in accordance with criteria of the Secretary) in, services that would otherwise be provided, and (B) Federal funds made available under this part for any period will be so used as to supplement and, to the extent practical, increase the level of State, local, and other non-Federal funds, including third party health insurance payments, that would in the absence of such Federal funds be made available for the program described in paragraph (2) of this subsection and will in no event supplant such State, local, and other non-Federal funds; and

(5) the services to be provided by the center are described in the State mental health plan submitted to the Public Health Service by the State mental health authority in accordance with title III of the Public Health Service Act.

Notwithstanding the provisions of paragraph (2) of this subsection, the requirement therein with respect to essential elements of comprehensive mental health services shall not apply, in the case of an application for a grant to any center which will provide services in an area designated by the Secretary as an urban or rural poverty area, for the eighteen-month period commencing on the date such application is filed, if the Secretary is satisfied that such center will meet such requirement prior to the end of such period; however, if such center has not by the end of such eighteen-month period met such requirement, payments under any grant (made under such application) to such center shall be suspended until the Secretary determines that the center has met such requirement.

Restriction upon making grant

(b) No grant may be made under this part after June 30, 1974, with respect to any community mental health center or

with respect to any type of service provided by such a center unless a grant with respect thereto was made under this part prior to July 1, 1974.

Programs for drug addicts and other persons with drug abuse and other drug dependence problems; authorization of appropriations

(c) If an application for a grant under this part for a community mental health center is made for any fiscal year beginning after June 30, 1972, and—

(1) the Secretary determines that it is feasible for such center to provide a treatment and rehabilitation program for drug addicts and other persons with drug abuse and other drug dependence problems residing in the area served by the center and that the need for such a program in that area is of such a magnitude as to warrant the provision of such a program by the center, such application may not be approved unless it contains or is supported by assurances satisfactory to the Secretary that the center will provide such program in such fiscal year; or

(2) the Secretary determines that it is feasible for the center to assist the Federal Government in treatment and rehabilitation programs for drug addicts and other persons with drug abuse and other drug dependence problems who are in the area served by the center, such application may not be approved unless it contains or is supported by assurances satisfactory to the Secretary that the center will enter into agreements with departments or agencies of the Government under which agreements the center may be used (to the maximum extent practicable) in treatment and rehabilitation programs (if any) provided by such departments or agencies.

For the purpose of making grants under this part to assist community mental health centers to meet the requirements of this subsection there are authorized to be appropriated $60,000,000 for the fiscal year ending June 30, 1973, $60,000,000 for the fiscal year ending June 30, 1974, and $60,000,000 for the fiscal year ending June 30, 1975.

Pub.L. 88-164, Title II, §221, as added Pub.L. 89-105, §2(b), Aug. 4, 1965, 79 Stat. 428, and amended Pub.L. 90-31, §3(a), June 24, 1967, 81 Stat. 79; Pub.L. 91-211, Title II, §§203, 204(c), Mar. 13, 1970, 84 Stat. 57; Pub.L. 92-255, Title IV, §401(a), Mar. 21, 1972, 86 Stat. 76; Pub.L. 93-45, Title II, §203(a), June 18, 1973, 87 Stat. 94.

APPENDIX C

[¶ 5461] Seed-Money Grants (Prov. Reimb. Manual § 612.2)

Grants designated for the development of new health care agencies or for expansion of services of established agencies are generally referred to as "seed money" grants. "Seed money" grants are not deducted from costs in computing allowable costs. These grants are usually made to cover specific operating costs or group of costs for services for a stated period of time. During this time, the provider will develop sufficient patient caseloads to enable continued self-sustaining operation with funds received from Medicare reimbursement as well as from funds received from other patients or other third-party payers.

APPENDIX D

OPINION OF THE COURT

ALDISERT, *Circuit Judge*.

This appeal requires us to decide if there is a federal question jurisdiction under 28 U.S.C. § 1331(a)[1] to hear a claim brought by nine community hospitals against Blue Cross of Western Pennsylvania. The hospitals originally filed suit in the Court of Common Pleas of Westmoreland County, Pennsylvania to enjoin Blue Cross from computing reimbursement payments in a certain manner and to recover money damages. Blue Cross removed the action to the district court. The hospitals' motion to remand to the state court was denied and judgment on the merits was entered in favor of Blue Cross. The hospitals have appealed. Determining that proper subject matter jurisdiction exists, we affirm.

This case is an outgrowth of two successive cost-reimbursement contracts, entered on July 1, 1966 and July 1, 1973, between the hospitals and Blue Cross. Under the terms of the contracts, Blue Cross agreed to pay for the medical care and treatment provided by the hospitals to Blue Cross subscribers. The agreements provided that the hospitals would charge Blue Cross only their costs attributable to rendering service to subscriber patients, rather than their standard rate. The computation of these costs involved what the district court described as "a complicated formula" that had been developed over several decades.[2] Traditionally, Blue Cross has taken the position that federal grants

[1]28 U.S.C. § 1331(a) provides:

> The district courts shall have original jurisdiction of all civil actions wherein the matter in controversy exceeds the sum or value of $10,000, exclusive of interest and costs, and arises under the Constitution, laws, or treaties of the United States except that no such sum or value shall be required in any such action brought against the United States, any agency thereof, or any officer or employee thereof in his official capacity.

[2]Appendix at 65a.

awarded to hospitals are to be treated as restricted funds, and as such, not included in hospital operating costs, under the theory that only the actual costs incurred by the hospital itself for patient care and service should be factored into the amount borne by Blue Cross. What gave rise to this litigation was the application by Blue Cross of its accounting practice to a number of grants to appellants under the Community Mental Health Centers Act. 42 U.S.C. § 2688 to § 2688v (current version at 42 U.S.C. § 2689 to § 2689aa).

Under the Act, the Department of Health, Education and Welfare (HEW) administers the mental health program under which these hospitals have qualified for federal grants by providing community mental health services. One of the various grants, deemed central to this dispute, is designated as the mental health staffing grant, which is measured by a percentage of the total projected expenses for wages and salaries for professional and technical employees to staff the mental health centers. HEW required that staffing grants not be used to "supplant" amounts which would otherwise be received by the hospitals from insurance companies or other third-party payers. 42 U.S.C. § 2688 (a)(4).[3] At various times since 1966 each of the hospitals has organized a community

[3]42 U.S.C. § 2688a(a)(1975), provided:

> Grants under this part with respect to any community mental health center may be made only upon application, and only if—
>
> • • • •
>
> (4) the Secretary determines that there is satisfactory assurance that (A) the services to be provided will constitute an addition to, or a significant improvement in quality (as determined in accordance with criteria of the Secretary) in, services that would otherwise be provided, and (B) Federal funds made available under this part for any period will be so used as to supplement and, to the extent practical, increase the level of State, local, and other non-Federal funds, including third party health insurance payments, that would in the absence of such Federal funds be made available for the program described in paragraph (2) of this subsection and will in no event supplant such State, local, and other non-Federal funds.

mental health center to provide the services and facilities authorized by federal law. Federal staffing grants allotted to them, already paid and forecast for the future, amount to approximately $28,000,000.

The Blue Cross accounting practice treated the federal grants as restricted funds, and in computing reimbursable costs to the hospitals, excluded the federal staff grants in determining the actual operating costs of the hospital. The hospitals, beginning in 1971 with the South Hills Health System, objected to this practice. South Hills contended that Blue Cross had no right to deduct the federal grants from the hospital's ordinary costs of operation because, in a related program (Medicare), Blue Cross had accepted HEW's designation that certain "start-up" grants were "seed grants" and did not require them to be applied to costs. South Hills wanted similar treatment for the mental health staff grants. As early as 1971, then, member hospitals and Blue Cross had begun a running disagreement over the accounting treatment by Blue Cross of the federal staffing grants.

HEW agreed with the hospitals' interpretation of their Blue Cross contracts and contended that the Blue Cross accounting treatment was tantamount to a violation of 42 U.S.C. § 2688a(a)(4) because, in the absence of federal grants, Blue Cross would have included mental health center staff costs as reimbursable operating costs of the hospital. HEW also contended that the Blue Cross contract was unenforceable as against public policy. When Blue Cross rejected the interpretation urged by the hospitals, HEW threatened to cut off the grants to the *hospitals!* Thus, to use the current idiom, the appellant hospitals found themselves between a rock and a hard place—they valiantly sought reimbursement from Blue Cross, yet when they failed, HEW threatened to close off grants to them because Blue Cross interpreted the contract differently from the way HEW did. The district court has accurately described the situation:

The Secretary was aware of the controversy and, in fact, caused it. He had urged the hospitals to negotiate a change in the practice used by Blue Cross because the more money Blue Cross paid the hospitals, the better chance they would have of surviving without federal money, but Blue Cross wanted to protect its subscribers and its rates. The more Blue Cross had to pay, the higher the rates it would have to charge. Blue Cross said its subscribers would be subsidizing the taxpayers unless it was permitted to treat the federal grants as restricted grants. As was apparent to everyone, Blue Cross spends only its subscribers' money and the Secretary spends only the taxpayers' money. Finally, the Secretary precipitated this litigation when he threatened to cut off the staffing grants. The hospitals were placed in the middle because they could not operate the mental health clinics without the grants.

Appendix at 67a.

Thus it cannot be said that HEW was a casual bystander to the contract dispute. If the contract formed the basis of the controversy, it was the threatened HEW action that precipitated the present litigation.

Faced with these pressures, the hospitals filed suit seeking money damages from Blue Cross for alleged breaches of the contracts and injunctive relief to prevent Blue Cross from deducting the grants from the amount of allowable hospital costs. After removal, HEW was added as an indispensable party under Rule 19 of the Federal Rules of Civil Procedure, whereupon the Secretary counterclaimed against eight of the hospitals to recover for allegedly erroneous grant payments, claiming that the hospitals had breached the provisions of the post-1975 grants. The district court ruled in favor of Blue Cross on the hospitals' claim and in favor of the hospitals on the Secretary's counterclaim. Only the hospitals have appealed.

I.

The essence of the appellants' jurisdiction argument is that the state court action involved only a contract, to be interpreted under the common law of Pennsylvania, and that no federal question appeared in its theory of the case. Blue Cross argues that the federal question appears on the face of the complaint and that interpretation of federal statutes permeates the entire controversy.

We start from the premise that for a civil action to arise under 28 U.S.C. § 1331(a), the "right or immunity created by the Constitution or laws of the United States must be an element, and an essential one, of the plaintiff's cause of action" and that "the controversy must be disclosed upon the face of the complaint, unaided by the answer or by the petition for removal." *Gully v. First National Bank*, 299 U.S. 109, 112-13 (1936). An unwavering series of Supreme Court decisions has emphasized this rule. *See e.g., Tennessee v. Union & Planters' Bank*, 152 U.S. 454 (1894); *Phillips Petroleum Co. v. Texaco, Inc.*, 415 U.S. 125 (1974) (per curiam).

Furthermore, federal removal procedure clearly requires that the initial pleading in the state court must set forth the basis for removal. 28 U.S.C. § 1446(b). The Supreme Court has instructed us that the removal procedure reflects a congressional policy of severe abridgment of the right to remove a state action to federal court. In adjuring strict construction of the removal statutes, the Court has cautioned:

> Not only does the language of the [removal statute, 28 U.S.C. § 1441] evidence the Congressional purpose to restrict the jurisdiction of the federal courts on removal, but the policy of the successive acts of Congress regulating the jurisdiction of federal courts is one calling for the strict construction of such legislation. The power

> reserved to the states under the Constitution to provide for the determination of controversies in their courts, may be restricted only by the action of Congress in conformity to the Judiciary Articles of the Constitution. "Due regard for the rightful independence of state governments, which should actuate federal courts, requires that they scrupulously confine their own jurisdiction to the precise limits which the statute has defined." *Healy v. Ratta*, 292 U.S. 263, 270.

Shamrock Oil & Gas Corp. v. Sheets, 313 U.S. 100, 108-09 (1941) (other citations omitted). *See also American Fire & Casualty Co. v. Finn*, 341 U.S. 6, 10 (1951).

There is much force to the appellants' contention that their claim for relief involved only the interpretation of the Blue Cross contract under Pennsylvania law. Certainly, this was the theory on which the law suit was ultimately decided. But our inquiry as to the presence of federal jurisdiction is not on the basis of how a complaint *could* have been structured or of what theory was eventually relied upon at trial. As in *La Chemise Lacoste v. Alligator Co.*, 506 F.2d 339, 343 (3d Cir. 1974), we perceive our task to require an examination of "the face of the complaint" for a federal question. Generally speaking, the nature of plaintiffs' claim must be evaluated, and the propriety of remand decided, on the basis of the record as it stands *at the time the petition for removal is filed. Pullman v. Jenkins*, 305 U.S. 534, 537 (1939).

Our examination discloses that, unlike the situation in *La Chemise Lacoste*, where the federal question was introduced in the defense pleadings, here the plaintiffs' complaint introduced the federal question. Paragraphs 9, 12 and 13 of the complaint made reference to the federal statutes in question; ¶ 14 described the federal grants in detail. Paragraph 15 was an averment of the mandatory sanction of federal law:

> The federal law and/or regulations having the force and effect of law pertaining to seed money grants requires grantees such as plaintiff(s) to exert their/its best efforts to secure additional financing from sources other than the federal government, including insurance companies such as Blue Cross, to insure that the mental health care program will continue as a viable service after exhaustion of the seed money grants.

Appendix at 10a.

Notwithstanding their contention that it would have been possible to decide the contract dispute solely on state law precepts, we see that appellants gratuitously volunteered on the face of their complaint legal conclusions based on federal statutes and regulations. Although these allegations may have been unnecessary for the ultimate disposition of the case, and here we are accepting the appellants' premise, surplusage of federal claims in pleadings is not the test. A subsequent amendment to the complaint after removal designed to eliminate the federal claim will not defeat federal jurisdiction. *Hazel Bishop, Inc. v. Perfemme, Inc.*, 314 F.2d 399 (2d Cir. 1963). "The nature of the relief available after jurisdiction attaches is, of course, different from the question whether there is jurisdiction to adjudicate the controversy." *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557, 561 (1968). We cannot say that as drafted and filed in the state court, the complaint did not require construction of a federal statute for its disposition. *See Lindy v. Lynn*, 501 F.2d 1367, 1369 (3d Cir. 1974).

This in itself would have been sufficient to vest federal jurisdiction, but appellants made additional averments in their complaint that militate against the contentions they now urge on appeal. In ¶ 35, they averred that

> the federal government, through HEW, has given notice to plaintiff(s) that they/it is/are and will be in

> violation of the conditions attached to the grants and ineligible for allotted staffing grant monies or terminated from the grant program until Blue Cross conforms with the condition that it give proper recognition to the seed money grants and not receive any benefit from the grant and, further, that applicable law requires restitution by the plaintiff(s) to HEW of those staffing grant amounts already paid unless Blue Cross makes proper restitution to said plaintiff(s). The date set for the discontinuance of funding is January 1, 1977. Letters from HEW setting forth that position are attached hereto as Exhibits "A", "B" and "C" and intended to become part hereof.

Appendix at 14a. Paragraph 35 heightens the federal overtones of this litigation and makes applicable what we said in *Lindy v. Lynn:* "An action arises under the laws of the United States... if it requires the construction of a federal statute or a distinctive policy of a federal statute requires the application of federal legal principals for its disposition." 501 F.2d at 1369.

Thus, notwithstanding the restrictive congressional policy against removal, *American Fire & Casualty Co. v. Finn*, 341 U.S. 6 (1951), appellants' argument cannot succeed. To accept their contention would require us to evaluate the question of federal jurisdiction at the time of trial in the federal court and to decide that subject matter jurisdiction did not obtain because appellants went to trial on state law theories only. To do so would be to ignore the rule in removal cases that subject matter jurisdiction is to be determined from the face of the complaint and on the basis of the record in the state court, *at the time* the petition for removal is presented. The hospitals' complaint, so viewed, reveals alternative bases for relief against Blue Cross, namely, that the hospitals were entitled to relief under the contract whether it was interpreted according to state law principles *or* under the federal mental health statutes. Because appel-

lants' complaint was based in part on federal statutes, and federal agency regulations and interpretations, we conclude that there was jurisdiction under 28 U.S.C. § 1331(a). It is immaterial that at trial appellants relied solely on state law principals to make their case.

II.

On the merits, we have no difficulty affirming the judgment of the district court essentially for the reasons set forth in its opinion, Appendix at 64a-88a. The trial court determined, and we agree, that a restricted grant had been recognized by both Blue Cross and the hospitals as a grant to be used for a specific purpose and that the parties had followed

> the practice, usage and custom of having costs determined by annual audits in which restricted grants were deducted in figuring allowable costs. They did this knowingly and intentionally. The contracts thus encompassed the custom employed. In fact, the custom was to allow Blue Cross to establish the accounting practices and to administer them and to determine what grants were to be excluded in figuring reimbursible costs in some 100 hospitals which served some 2,500,000 Blue Cross subscribers. The determination of allowable costs did not include restricted grants. Restricted grants were grants made for a specific purpose.

Appendix at 72a-73a.

The district court also determined

> that for purposes of the administration of the contracts between Blue Cross and the hospitals, the federal grants were restricted grants because they were to be used strictly for purposes of paying staff salaries. Under the Blue Cross contracts, both the 1966 and the 1973 contracts and other contracts dating back to the early 50's, the hospitals had given Blue Cross the privilege of establishing the accounting procedure to be used.

Appendix at 74a.

In a thoughtful analysis of HEW's contention that the Blue Cross contract was void as against public policy, Judge McCune concluded:

> We find that the Secretary, until this litigation, has never had a policy on this issue and has never contended that deduction of the grants is opposed to the law or public policy. Nor has he held hearings to establish a policy pursuant to his official regulations.
>
> We refuse to find the Blue Cross contracts illegal or opposed to public policy. None of the Amendments in plain language made the practice, which was part of the contracts, illegal or opposed to public policy.

Appendix at 78a. Apparently HEW has acquiesced in the court's rejection of its contention and denial of its counterclaim. An appeal previously lodged by HEW was withdrawn prior to briefing.

The judgment of the district court will be affirmed.

To The Clerk

Please file the foregoing opinion.

Circuit Judge

APPENDIX E

No. 78-2491

WESTMORELAND HOSPITAL ASSOCIATION, a non-profit corporation, LATROBE AREA HOSPITAL, a non-profit corporation, THE ALTOONA HOSPITAL, a non-profit corporation, THE HAMOT MEDICAL CENTER OF ERIE, PENNSYLVANIA, a non-profit corporation, MEADVILLE CITY HOSPITAL, a non-profit corporation, SAINT VINCENT HEALTH CENTER, a non-profit corporation, COMMUNITY MENTAL HEALTH CENTER OF BEAVER COUNTY, a non-profit corporation, SOUTH HILLS HEALTH SYSTEM, a non-profit corporation, and HENRY CLAY FRICK COMMUNITY HOSPITAL, a non-profit corporation,

Appellants

vs.

BLUE CROSS OF WESTERN PENNSYLVANIA, a non-profit corporation, SECRETARY OF HEALTH, EDUCATION AND WELFARE

(D.C. Civil Action No. 76-1622)

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

Present: ALDISERT, VAN DUSEN and WEIS, *Circuit Judges*

JUDGMENT

This cause came on to be heard on the record from the United States District Court for the Western District of Pennsylvania and was argued by counsel on August 7, 1979.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said District Court filed August 14, 1978, be, and the same is hereby affirmed. Costs taxed against appellants.

Attest:

/s/ BETTY J. ROBINSON
Deputy Clerk

September 10, 1979

APPENDIX F

IN THE

United States District Court

FOR THE WESTERN DISTRICT OF PENNSYLVANIA

(Filed August 14, 1978.)

WESTMORELAND HOSPITAL ASSOCIATION, a non-profit corporation, LATROBE AREA HOSPITAL, a non-profit corporation, THE ALTOONA HOSPITAL, a non-profit corporation, THE HAMOT MEDICAL CENTER OF ERIE, PENNSYLVANIA, a non-profit corporation, MEADVILLE CITY HOSPITAL, a non-profit corporation, SAINT VINCENT HEALTH CENTER, a non-profit corporation, COMMUNITY MENTAL HEALTH CENTER OF BEAVER COUNTY, a non-profit corporation, SOUTH HILLS HEALTH SYSTEM, a non-profit corporation, and HENRY CLAY FRICK COMMUNITY HOSPITAL, a non-profit corporation,

Plaintiffs

vs.

BLUE CROSS OF WESTERN PENNSYLVANIA, a non-profit corporation,

and

SECRETARY, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE,

Defendants

Civil Action No. 76-1622

OPINION

BARRON P. MCCUNE, *District Judge*
August 14, 1978.

The plaintiffs, all non-profit hospitals in Western Pennsylvania, brought suit in the Court of Common Pleas of Westmoreland County against Blue Cross of Western Pennsylvania, a non-profit corporation on October 20, 1976. The suit sought to enjoin Blue Cross from figuring so-called reimbursable costs to the hospitals in the manner then employed by Blue Cross and sought money damages from Blue Cross. The complaint alleged that the hospitals had been notified by the Secretary of Health, Education and Welfare, that certain federal grants would be discontinued on January 1, 1977, unless the hospitals forced Blue Cross to change the method of determining what health care costs Blue Cross would pay the hospitals. Blue Cross and the hospitals had been under contract with each other for many years. They had developed a complicated formula by which the costs of furnishing care to Blue Cross subscribers in the hospitals would be charged to Blue Cross. The payments which Blue Cross had made to the hospitals had been a major source of their income from the early 1950's. In Western Pennsylvania about one-third of all hospital patients are covered by Blue Cross contracts.

In 1963 Congress, seeking to improve the lot of people with mental health problems, enacted P.L. 88-164 entitled "The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963," 42 U.S.C. §2661, et seq.

This act entitled the Commonwealth of Pennsylvania (and the other states) to certain funds if the state developed a comprehensive mental health plan which would make mental health care available in the communities. The Commonwealth developed such a plan. The Act was amended at various times. Of particular interest here were the amend-

ments of 1965 (P.L. 89-105) 42 U.S.C. §2688, *et seq.*, and of 1975, (P.L. 94-63) 42 U.S.C. §2689, *et seq.*

The intent of the 1963 Act was to encourage communities to establish mental health centers and the purpose of the 1965 amendment was to furnish part of the cost of staffing the centers, i.e., paying the salaries of staff and technical personnel.

Later amendments provided for additional funding for staff for up to a maximum of eight years. The overall plan was that the costs of these centers would gradually be taken over by the communities. (We note parenthetically that the plan was not realistic in this respect).

At issue here is the so called "supplement not supplant" language of 42 U.S.C. §2688(a) as amended.[1] This language required the Secretary to be assured in making staffing grants that they would supplement, and not supplant, other available funds. The Secretary took the position that federal funds were supplanting Blue Cross funds because of the method used by Blue Cross in determining health care costs.

The plaintiff community hospitals established mental health centers pursuant to this legislation and at various times prior to the commencement of this litigation, applied for federal staffing grants pursuant to the 1965 amendment and

[1]Under the 1975 Amendment, §206(2)(B)(ii) of the Act, 42 U.S.C. §2689(e), the Secretary could approve an application for a grant under §§203, 204 or 205 only if he determines that the application contains or is supported by satisfactory assurances that federal funds made available under §§203, 204 or 205, as the case may be, will (1) be used to supplement and, to the extent practical, increase the level of state, local and other non-federal funds, including third-party health insurance payments, that would, in the absence of such federal funds, be made available for the applicants' comprehensive mental health services and (2), in no event supplant such state, local and other non-federal funds.

The language of 42 U.S.C. §2689(e) is not substantially different from that of 42 U.S.C. §2688(a), which was in effect prior to the 1975 amendment.

later amendments. The grants were made over a period of years and the plaintiff hospitals have used the staffing grants. When the grants were applied for, the hospitals made the assurances which the law required.

Under the contracts which Blue Cross had negotiated with the hospitals over the years, Blue Cross took the position that the federal grants for paying staff, from the inception of the program, should be treated as restricted funds, much like a grant from a private foundation, so when the cost of patient care to Blue Cross subscribers was figured, the federal grants were excluded from the cost figures. Cost figures ordinarily included all salaries but since part of the salaries of the staff had been furnished by a grant, the amount of the grant was excluded in figuring costs. In this manner, for bookkeeping purposes, the money the hospitals showed as costs (total costs) was less than the total costs they would have shown if the federal grants had been thrown into total costs.

Because the Blue Cross hospital formula for determining what Blue Cross paid the hospitals was based on the total cost of furnishing health care to Blue Cross subscribers, it made a difference for bookkeeping and billing purposes whether the hospitals included the grants in figuring costs, or whether the federal grants were treated as restricted acquisitions which were not included in costs.

It was apparent to everyone that if the hospitals' costs were increased, the money Blue Cross paid to hospitals for care to its subscribers would increase, so if the federal grants were treated as costs, Blue Cross would be paying the hospitals more money.

It was also apparent to everyone that Blue Cross was treating the federal grants as restricted grants, not included in the money the hospitals called costs of furnishing care to Blue Cross subscribers.

It was apparent, to repeat, that if the federal grants were included as costs, Blue Cross would owe the hospitals more than they were being paid.

A controversy developed over this question as far back as 1971—how should the federal grants be treated for bookkeeping purposes between the hospitals and Blue Cross? The hospitals and Blue Cross and the Secretary all knew that the contracts between the hospitals and Blue Cross did not refer to staffing grants, or for that matter, to restricted grants or grants of any kind.

The Secretary was aware of the controversy and, in fact, caused it. He had urged the hospitals to negotiate a change in the practice used by Blue Cross because the more money Blue Cross paid the hospitals, the better chance they would have of surviving without federal money, but Blue Cross wanted to protect its subscribers and its rates. The more Blue Cross had to pay, the higher the rates it would have to charge. Blue Cross said its subscribers would be subsidizing the taxpayers unless it was permitted to treat the federal grants as restricted grants. As was apparent to everyone, Blue Cross spends only its subscribers' money and the Secretary spends only the taxpayers' money. Finally, the Secretary precipitated this litigation when he threatened to cut off the staffing grants. The hospitals were placed in the middle because they could not operate the mental health clinics without the grants.

Blue Cross removed the complaint to this court. We refused to dismiss the complaint on the ground that an indispensable party was missing. Believing that the Secretary of HEW was involved and federal funds were in issue, we refused to remand on motion of plaintiffs and we added the Secretary of Health, Education and Welfare as an indispensable party under Rule 19 by court order.

The relief necessary to keep the money coming to the hospitals was negotiated, the Secretary kindly agreeing to maintain the grants until this litigation was finally decided and Blue Cross agreeing to escrow certain funds meanwhile. The hospitals claim large amounts of money to be due, alleging breach of contract and violation of public policy and the Secretary claims money from the hospitals by way of reimbursement, having filed a counterclaim against the hospitals[2] on the theory that the grants were made were not true.

Conciliation of the entire controversy proved to be impossible, and the question was litigated extensively, the actual trial beginning June 15, 1977, non jury, and ending August 16, 1977.

Blue Cross answered that under the contract of July 1, 1973, which succeeded a contract of July 1, 1966, which succeeded one in 1951, the principle of deductibility of restricted grants from a hospital's costs was a part of the contracts because such practice had been followed consistently by the parties for many years. It also averred that the hospitals had been aware of this practice prior to the time the first federal grants had been applied for and that the hospitals were guilty of laches and also of estoppel. It answered that the Secretary knew of the practice before the grants were made and he was also estopped to complain; that the practice was not affected by the legislation, was not opposed to public policy and that Blue Cross money was not being supplanted by the federal grants in any event as a matter of fact.

All of the money in question is money given by the federal government to pay the staff people who run the mental health clinics. The hospitals and the Secretary call

[2]The Secretary claims only the money paid after the amendment of the Act by P.L. 94-63, the 1975 amendment.

this unrestricted or "seed" money. Blue Cross calls it "restricted money".[3]

A Motion for Partial Summary Judgment requesting that we find Blue Cross in violation of the contracts was denied because of the presence of issues of fact. As will be seen later on, there has been considerable subsidizing of mental health care by both Blue Cross and the Federal Government. We conclude that Blue Cross owes nothing to the hospitals and that the hospitals owe nothing to the Federal Government.

In deciding the questions presented, we must decide whether the Blue Cross contracts with the hospitals did contemplate the exclusion of "restricted grants" in figuring reimbursable costs; whether the grants were restricted grants for purposes of the contracts; whether the law forbade what the parties had contracted to do; whether there was any supplanting in any event as a factual matter and

[3]The extent of a mental health staffing grant is measured by a percentage of the total projected expense for wages and salaries for professional and technical employees to staff the centers. The top percentage varies from 90% in poverty areas to 75% in non-poverty areas and extends for a maximum of eight years at a declining rate each year.

To obtain a grant a health center must assure the Secretary that the staffing grant will not be used to supplant amounts which would otherwise be received from others including third-party payors, 42 U.S.C. §2688(a).

Each of plaintiff hospitals has, since 1966, received a staffing grant: South Hills (originally Homestead) beginning 1969, Community Mental Health Center of Beaver County in 1970, Latrobe Area Hospital in 1971, St. Vincent Health Center in 1972, Altoona Hospital in 1972, Hamot Medical Center of Erie in 1973, Henry Clay Frick Community Hospital in 1973, Meadville City Hospital in 1973, and Westmoreland Hospital Association in 1974.

The grants paid to date and forecast total about $28,000,000.00.

The plaintiffs estimate that if the grants had not been deducted by Blue Cross, it would have paid the hospitals about $4,000,000.00 more over the life of the grants.

finally, whether the hospitals owe the Federal Government any money.

We start our analysis with the contracts.

Did the Contracts Permit Blue Cross to Deduct Restricted Grants?

Neither the 1966[1] nor the 1973 contracts, or any prior ones, mention restricted grants as such, but there is no question that restricted grants had been recognized by both the hospitals and Blue Cross for many years as being deductible from hospital costs before reimbursable costs were figured. Occasionally the parties argued over what was restricted and what was not restricted, but the principle was recognized that if a gift or grant was made to a hospital for a specific purpose, that particular cost had been picked up by the hospital or satisfied from some particular source and the hospital could then not charge that cost to Blue Cross. For example, if a philanthropic citizen donated $50,000.00 to pay the salary of the director of the nursing service for one year, Blue Cross could not be charged with the salary of the director when reimbursable costs were figured.

For example, if another citizen donated money to buy x-ray film for a year, Blue Cross was not charged the cost of x-ray film in figuring reimbursable costs for that year.

Blue Cross historically had never paid the usual and ordinary hospital charges when its subscribers used the hospitals. It paid somewhat less than the charges based upon the formula set forth in the contracts. This practice began in 1951. Reimbursable costs were figured on the basis of a hospital's actual costs. This gave Blue Cross subscribers a

[1]The 1966 contract applies only to South Hills, Community Mental Health Center of Beaver County, Latrobe Area Hospital, St. Vincent Health Center, and the Altoona Hospital while the 1973 contract applied to all plaintiffs.

favorable rate but it gave hospitals dependable income which they needed to exist.

The contracts did not define what costs were and merely provided that costs (for purposes of applying the formula) would be determined after audit by Blue Cross on the basis of data submitted by the hospital in its financial reports to the Commonwealth or other comparable data. Neither the 1966 or the 1973 contract, or preceding contracts, set forth what would be included in costs or excluded from costs, but referred simply to costs. The 1966 contract referred merely to "costs". The 1973 contract referred merely to "allowable costs".

In practice, at the end of each fiscal year, Blue Cross would audit the hospitals and allow certain costs as allowable and exclude certain costs as not allowable. There would be a meeting where negotiations would occur and disputed items would finally be agreed upon. Restricted grants were recognized as grants made for particular purposes.

Blue Cross clearly showed, in our opinion, that under the contracts, this practice had prevailed since 1951. Blue Cross was permitted to establish the accounting principles employed in the audits and by custom and usage restricted grants were excluded in figuring costs because otherwise the hospitals would receive a double payment for the same element of cost.

The practice was well known by HEW as early as 1969. HEW continued to make the grants, however, after it learned of the practice. Although it wrote to plaintiffs on May 16, 1975, and again on October 17, 1975, objecting that plaintiffs had allowed the practice to continue.

In respect to the Blue Cross contracts in dispute here, they are unique and differ from those of the other Blue Cross organizations in Pennsylvania. They appear to be similar to

the Blue Cross contract in force in Michigan as will be explained later on.

A restricted grant has been defined and recognized by the American Hospital Association and by the Commonwealth for purposes of Medicaid reimbursement, as a grant to be used for a specific purpose. The definition has been recognized by the Federal Government for purposes of Medicare reimbursement.

We find that the parties did follow the practice, usage and custom of having costs determined by annual audits in which restricted grants were deducted in figuring allowable costs. They did this knowingly and intentionally. The contracts thus encompassed the custom employed. In fact, the custom was to allow Blue Cross to establish the accounting practices and to administer them and to determine what grants were to be excluded in figuring reimbursable costs in some 100 hospitals which served some 2,500,000 Blue Cross subscribers. The determination of allowable costs did not include restricted grants. Restricted grants were grants made for a specific purpose.

There were occasions when restricted grants were not deducted before figuring reimbursable costs but these exceptions were based upon sound reason. For example, a grant to Latrobe Hospital of $50,000.00 from one of the Mellon foundations was, by agreement, found to be unrestricted since it could be used for the general purposes of the Mental Health Clinic. Four other instances where the practice was not followed were satisfactorily explained.

Until this controversy arose, the custom was not disputed by the hospitals which generally deducted restricted grants in figuring their own costs prior to the Blue Cross audits.

The 1973 contract was negotiated with the Joint Hospital Reimbursement Committee, established by the Hospital

Council of Western Pennsylvania and by the Northwest Hospital Conference. The administrators of Hamot Medical Center and Meadville City Hospital and Frick Community Hospital served on the committee while they had applications pending for staffing grants, but no one, during negotiations, suggested any provision changing the prevailing custom dealing with the staffing grants. There was a provision inserted in the contract dealing with education and research and providing for non-deduction of certain of such grants but this provision was a requirement of the Pennsylvania Insurance Deaprtment and not of the hospitals.

Meadville, by its Controller, approved the audit for the year ending June 30, 1974, as did the South Hills Hospital and Hamot Hospital in which the federal grants were deducted. The Mental Health Center of Beaver County also approved it. Altoona Hospital, in calculating per diem costs for the year ending June 30, 1975, and 1976, deducted the grants as did St. Vincent for the year 1976.

There was no breach of contract by Blue Cross when it deducted the federal staffing grants. It was following the practice established long before the staffing grants were applied for.

Were the Grants Restricted Grants for Purposes of the Contracts?

We find that for purposes of the administration of the contracts between Blue Cross and the hospitals, the federal grants were restricted grants because they were to be used strictly for purposes of paying staff salaries. Under the Blue Cross contracts, both the 1966 and the 1973 contracts and other contracts dating back to the early 50's, the hospitals had given Blue Cross the privilege of establishing the accounting procedure to be used.

(The contracts, including the 1973 contract, provided for a dispute committee to resolve disputes arising between the parties. In June of 1976, such a committee held a hearing and recommended a method of settling the dispute which, although acceptable to Blue Cross, was not acceptable to the plaintiffs. That recommendation would have resulted in an accounting method by which the staffing grants would not have been deducted but reimbursable costs to the hospitals would have been figured on a basis similar to the method used by Medicare. The Secretary would have approved such a plan. The disputes committee had no power to bind the parties, however).

The definition of a restricted grant had been well established in hospital accounting since 1953. In its publication "Principles of Payment for Hospital Care," of September, 1953, the American Hospital Association had defined such grants and had suggested that restricted grants, including government grants, be deducted in figuring reimbursable costs. This publication was revised in 1962, and in 1969, without change in this particular.

Starting in 1965, the federal government itself recognized the mental health staffing grants as restricted grants for purposes of Medicare reimbursement to hospitals and deducted the grants for such purposes until sometime in 1971 when the practice was changed in the so-called Federal Provider Reimbursement Manual, which then classified the grants as "seed money" grants and as such, not deductible for purposes of Medicare Reimbursement. But the Manual was admittedly applied only in Medicare reimbursement and neither the 1966 nor 1973 contract with Blue Cross required Blue Cross to follow the Medicare system of reimbursement.

In fact, Blue Cross of Western Pennsylvania does not follow the Medicare reimbursement formula. Medicare

reimburses hospitals in Western Pennsylvania about 4% less than average per diem costs. In the 1966 contract, Blue Cross agreed to increase its payments, an amount equal to about 4% more than the hospitals per diem costs, to make up the 4% lost to Medicare. As a result, in Western Pennsylvania, Blue Cross pays about 8% more than Medicare. This is what causes the statement that the Blue Cross contract in Western Pennsylvania is somewhat unique.

By terms of the Community Mental Health Centers Act, the services to be performed were new services which had never before been performed by community hospitals. The principle of deducting restricted grants had been adopted by the hospitals and Blue Cross long before the enactment of the Act. Thus, for the purposes of interpreting the hospital contracts, the staffing grants were restricted grants.

Did Federal Law Forbid the Practice Encompassed by the Contracts, by the 1965 Amendment?

This question might best be answered by the Secretary's brief, received June 21, 1977, arguing that the Blue Cross practice is opposed to public policy. The Secretary said this:

> "It should be noted initially that nothing is contained in the federal statute which would indicate that it is intended to control activities of this Blue Cross plan or any other third-party payor in applying a reimbursement formula. The Department of Health, Education and Welfare recognized that it had no privity with Blue Cross at an early stage of this dispute ...
>
> "As a general rule of law it is desirable that competent parties be protected in their rights to make and enforce agreements between themselves. Courts historically have been cautious in voiding a contract on the ground that it violates public policy and courts will not extend the public policy rule arbitrarily. All rights how-

ever are restricted by the Transcendent rule that denies enforceability to a private contractual provision which would affect the violation of paramount interests of the public generally."

The Secretary argues that since 42 U.S.C. §2668(a) as amended by 42 U.S.C. §2689(e), provided that federal funds made available were to be used to supplement, and to the extent practicable, increase the level of state, local and other non-federal funds, including third-party health insurance payments, the action of Blue Cross was opposed to public policy. This is the position, of course, which led to the threat to cut off the grants.

The hospitals adopt a similar argument, of course, now arguing that the intent of the legislation was to prohibit the deduction of the grants and therefore that the past action of Blue Cross was illegal and the present action of Blue Cross is illegal. The hospitals, of course, demand recalculation of their costs on this basis.

The question thus arises whether the legislation, in fact, made the action of Blue Cross illegal. We conclude that it did not make the action of Blue Cross illegal. The staffing grant legislation was not passed until 1965 when the contractual obligations of Blue Cross and the hospitals were firmly established.

The legislation did not expressly deal with the Blue Cross practice or make it illegal by clear and precise words. Unless a legislative body expressly states its intent to make a contract provision illegal, courts must ordinarily enforce the contract, *ETS-Hokin & Galvan, Inc. v. Maas Transport Inc.*, 380 F.2d 258 (8th Cir. 1967).

As early as 1969, Region II of HEW, which then had jurisdiction over Pennsylvania, was informed that Blue Cross of Western Pennsylvania deducted staffing grants in

determining cost reimbursement. Region III assumed jurisdiction in 1970. It learned of the practice on September 18, 1973. All of the grants were made following 1969 with full knowledge of the practice. The July 29, 1975 amendment to the Act did not make the practice illegal even though it was well known to the Secretary and could have been brought to the attention of the Congress.

The CMHC Policy and Standards Manual and the Federal Regulations, 42 C.F.R. ¶54.302(c), make no reference to the deduction of staffing grants by third party payors.

The Secretary continued to make grants in Michigan after learning on November 2, 1972, that Blue Cross of Michigan deducted such grants. The Secretary continued to make such grants because he was awaiting "the ascertaining of a national policy by the National Institute of Mental Health on such matter." As late as April 1, 1976, grants were made in Michigan.

We find that the Secretary, until this litigation, has never had a policy on this issue and has never contended that deduction of the grants is opposed to the law or public policy. Nor has he held hearings to establish a policy pursuant to his official regulations.

We refuse to find the Blue Cross contracts illegal or opposed to public policy. None of the Amendments in plain language made the practice, which was part of the contracts, illegal or opposed to public policy. In view of our conclusion that the legislation did not make the action of Blue Cross illegal, it is unnecessary to consider the application of the doctrines of laches or estoppel.

Was There Supplanting of Government Funds in Any Event When Blue Cross Deducted the Staffing Grants in Figuring Reimbursable Costs?

It is important to realize that before the Act of 1963, amended by the Act of 1965, heretofore cited, there were no

community Mental Health Centers. The federal grants were made to the community hospitals for the purpose of encouraging them to add new facilities. The Mental Health Centers or Clinics were supposed to charge for their services and they did so, but many people were unable to pay realistic charges, so charges were rather low. As might be assumed, a lot of the work of the centers was out-patient work. Alcoholism was the cause of much of the work. Of course, staffing was expensive. The plan conceived in the mind of Congress was that over the years the community hospitals would find sources of money sufficient that the federal government could pull out of the plan.

It appears that Blue Cross subscribers have been subsidizing a good portion of the costs of the mental health programs thus far and because of the formula Blue Cross uses in figuring reimbursable costs to the hospitals in Western Pennsylvania, the benefit to the hospitals may equal the benefit Blue Cross has obtained by deducting the staffing grants in figuring reimbursable costs.

In both the 1966 and 1973 contracts the formula applied was the ratio of charges to charges applied to costs, called the RCCAC formula. Under this formula, hospital costs were apportioned between in-patient costs and out-patient costs in the same proportion that the hospitals' charges were divided between in-patient charges and out-patient charges. As a result of applying the formula, a hospital's in-patient costs, for reimbursement purposes, increase in direct ratio to a decrease in the hospital's out-patient charges.

Under the formula, failure to charge for out-patient services or any decrease in out-patient charges or low out-patient charges, has the effect of increasing in-patient per diem costs and thus increasing Blue Cross' reimbursement to the hospitals.

In all of the plaintiff hospitals, based on the information submitted by them on their state reports, their mental health out-patient costs far exceeded the mental health out-patient charges. In other words, their charges to mental health out-patients were not covering their costs of servicing these patients. Since total hospital costs were subject to reimbursement, this had the effect of increasing the amount Blue Cross paid the hospitals year by year.

This was understood by the plaintiff hospitals. At least one administrator understood it and could explain it. In Exhibit Y, a letter of November 14, 1975, which Sister Margaret Ann Hardner, President of St. Vincent Health Center, wrote to George C. Gardner, M.D., Regional Health Administrator of Region III of HEW, she explained the application of the formula. The letter is lengthy and all of it is educational but in part she said this:

> "The following argument is known to both Blue Cross of Western Pennsylvania and the hospitals in question. It is not presented here in order to draw a conclusion as to its merits, but rather to provide additional understanding as to the complicated nature of the questions being discussed in Western Pennsylvania.
>
> "Blue Cross of Western Pennsylvania has very few benefit plans which include reimbursement for out-patient mental health services. St. Vincent is aware of no such plan in Northwestern Pennsylvania. Therefore, although only very few Blue Cross benefit plans cover out-patient mental health services, the total cost of these services are included in reimbursable cost under the Blue Cross reimbursement formula illustrated above. Therefore, Blue Cross actually pays for services which its benefit plans do not cover. Furthermore, as long as the present reimbursement formula is in use, Blue Cross will continue to pay for these services after the Federal Staffing grants in the area have been exhausted."

The letter continued with an analysis of the year 1975 in St. Vincent. Sister Hardner concluded with the following statement:

> "In summary, then it can be seen that in 1975 the amount by which the allowance of these out-patient costs increased the Blue Cross reimbursement exceeded the amount by which the offsetting of the staffing grant decreased the Blue Cross reimbursement."

It was thus apparent to Sister Hardner that the federal grants did not supplant Blue Cross money.

Referring to the individual hospitals and accepting the information they reported on their state reports, the following is found to be established:

1. Westmoreland Hospital Association's out-patient costs exceeded out-patient charges by a ratio of
   372.03% in 1976
   648.25% in 1975
   409.81% in 1974
   223.58% in 1973

2. Latrobe Area Hospital's out-patient costs exceeded out-patient charges by a ratio of
   281.29% in 1976
   339.85% in 1975
   287.68% in 1974
   449.55% in 1973

3. Altoona Hospital's out-patient costs exceeded out-patient charges by a ratio of
   296.39% in 1976
   241.31% in 1975
   267.99% in 1974
   363.27% in 1973

4. Hamot Medical Center's out-patient costs exceeded out-patient charges by a ratio of
   232.11% in 1976
   168.30% in 1975
   159.31% in 1974
   123.73% in 1973

5. Community Mental Health Center of Beaver County's out-patient costs exceeded out-patient charges by a ratio of
   156.75% in 1976
   195.26% in 1975
   241.55% in 1974
   223.85% in 1973

6. South Hills Health System's out-patient costs exceeded out-patient charges by a ratio of
   248.28% in 1976
   No figures available for 1975
   143.30% in 1974
   137.45% in 1973

7. Henry Clay Frick Community Hospital's out-patient costs exceeded out-patient charges by a ratio of
   107.63% in 1976
   157.43% in 1975
   196.73% in 1974

   (Not an accurate picture in this hospital because it deducted federal and state grants on its state reports).

All of this resulted in a proportionate increase in the in-patient per diem costs that were reimbursed by Blue Cross in each year, i.e., what Blue Cross paid was more than it would have been required to pay had mental health out-patient charges covered out-patient costs.

In view of the above figures, we accept the conclusion of Sister Hardner that Blue Cross is subsidizing the Mental Health Programs to a large extent.

To put it another way, Blue Cross, under its formula, paid the hospitals more than their charges for out-patient mental health care. Taking representative years for example, in the fiscal year ending June 30, 1975, Westmoreland's charges in its mental health program were $115,378.00.

As nearly as can be estimated on the basis of the testimony, Westmoreland was paid because of the advent of mental health out-patient services for that year, $246,347.00, which is $130,969.00 over its charges.

At Latrobe Hospital for the fiscal year ending June 30, 1974, the charges for mental health services were $105,785.00. For this program Blue Cross reimbursed Latrobe $138,851.00, or $33,066.00 more than its charges.

At St. Vincent for the fiscal year ending June 30, 1975, its charges were $260,533.00. It was reimbursed because of mental health services $336,401.00 or $75,868.00 more than its charges.

Thus, I am not convinced by a preponderance of the evidence that there has been any supplanting of private money by the federal grants as a matter of fact.

The above factual analysis perhaps illustrates why the hospital committee recommended a solution by which Blue Cross would cease deducting federal grants but the hospitals would agree to a revised formula more akin to the medicare formula by which to figure reimbursement.

It is understandable that the hospitals want a formula that will produce all possible revenue. They are sorely pressed for money as are Blue Cross subscribers. The cost of health care is a national problem defying solution. It must be conceded that the plaintiff community hospitals had in mind laudable objectives when they accepted the invitation of Congress and their mental health clinics should be continued if at all possible. We are not persuaded, however, that the

federal funds have supplanted the Blue Cross money as a matter of fact.

The Counterclaim by HEW

As heretofore noted, the Secretary has not claimed any money from the hospitals for grants made prior to the 1975 amendment to the Community Mental Health Care Act, effective July 29, 1975, see letter of John P. Panneton, Assistant United States Attorney, addressed to the court dated May 23, 1977. That letter, treated as an amendment to the counterclaim, states that

> "With respect to grants received under the Act subsequent to its amendment, the government takes a somewhat different stance. Initially it should be recognized that the awards made to the plaintiffs were erroneous and without legal authority since there was a failure to comply with the 'supplement not supplant' requirement."

The letter continues

> "However, if the grantees are able to recover the amount by which Blue Cross has reduced its reimbursement by reason of the grantees receipt of the grants, the government would not be required to recover the grant funds paid out improperly. This would not be required because the grantees would, in fact, have complied with the 'supplement not supplant' assurance which they gave the government originally."

The letter then said that

> "...in terms of future government expenditures, a recovery of post amendment funds would reduce the amount of the operating deficit of the hospitals and, consequently, the amount of future allowable grants. Thus monies attributable to post-amendment grants would be used to offset future government awards."

The meaning of this is that the Secretary seeks to enforce his counterclaim against the hospitals for post July 29, 1975 awards, not necessarily to obtain the money but to obtain a ruling that the awards were illegally obtained so that future grants may be reduced by the amount of the post amendment grants.

The question is presented therefore whether the grants made after July 29, 1975, were made erroneously and without legal authority.

The answer to the counterclaim filed by the hospitals stated that Blue Cross had attempted to benefit from the grants but that this was not with the consent of the hospitals, and although the hospital had applied for the grants and given the Secretary assurance that the federal funds would not supplant other funds, the grants were nevertheless legal and proper because it was Blue Cross' breach of contract which had caused the assurances to fail. The answer sort of infers that when the hospitals made the assurances, they didn't know that Blue Cross was going to do what it did.

This would be an insufficient answer if the Secretary were really serious about collecting from the hospitals because it is obvious that the hospitals knew of the practice of Blue Cross long before they made the assurances. The fact is that they made the assurance thinking they were proper and because the mental health centers were underway and had to be staffed and kept going and there was no way to keep them going without the federal grants.

The real reason for this litigation is that the Secretary has heretofore been uncertain what policy he should adopt. He has been searching for a policy ever since the practices of Blue Cross of Western Pennsylvania and Michigan were brought to his attention.

The Secretary has been unsure whether the Blue Cross contracts in those jurisdictions have been favorable or not from the federal viewpoint; whether there has been supplanting or not; whether the legislation controlled the contracts or not and finally, whether the hospitals have made sufficient assurances.

The Secretary has never known whether there was supplanting as a factual matter.

Now that this court has made the foregoing findings it can be concluded that his policy was correct all along in granting the funds to plaintiff hospitals on the basis of the assurances that they made. We conclude that the grants were not made erroneously and without legal authority.

In deference to the hospitals, however, it should be pointed out that they committed no wrong in making the assurances they made and they would have committed no wrong even if the Secretary had not known of the practice in Western Pennsylvania because the instructions they received did not tell them what supplanting consisted of. The instructions did not say that a hospital which permitted deduction of the federal grants in determining third party payor reimbursement was in violation of the law. The test for proper assurances inferred that if the hospitals assured the Secretary that they had maintained their past efforts, this was sufficient.

The test for compliance by the hospitals is set forth in 42 C.F.R. ¶54.302(c) which was in effect prior to the 1975 amendment. 42 C.F.R. ¶54.302(c) was not changed after the 1975 amendment, and states:

> "For purposes of Section 221(a)(4) of the Act with respect to assurances that Federal funds will not supplant non federal funds, budget information meeting the requirements of 54.305(b) sufficient to support a grant under 54.306, together with information providing an adequate basis for a determination by the Surgeon General under paragraph (d)(2)(iv) of this Section that there has not been a decline in State financial support shall be deemed to constitute such satisfactory assurance."

The above test was comprised of two elements: (1) budget information showing that in the fiscal year for which the grant was requested total expenditures for mental health services would exceed the average for the two-year period immediately preceding the initial grant period (42 C.F.R. ¶54.306 and (2), information must be available which would enable the Surgeon General to determine that the amount expended by the state during such year would not decline from the amount expended in the two preceding years (42 C.F.R. ¶54.302(d)(2)(iv)).

The test was published in a hand book by the Department of HEW called the CMHC Policy and Standards Manual. The test was published under the heading "Maintenance of Effort."

Maintenance of Effort

"The law requires that Federal staffing assistance must be used to supplement, and to the extent practical, increase the level of expenditures from state, local and other non-Federal sources of funds for the community mental health center securing the staffing grant. The same section of the law requires that in no event may Federal funds replace non-Federal funds.

"In order to show that these requirements will be made, applicants for staffing grants must show the levels of expenditures for mental health services which they and their predecessors and/or affiliates provided in the catchment area during the two years preceding the first year the center will operate. The applicant must assure that a minimum of the average expenditure for these two years plus the appropriate matching funds required for the year of operating will be expended in addition to the Federal grants."

There was another manual published by HEW called Community Mental Health Center Staffing Grant Program

Consultation Guide." The test was again listed under the heading "Maintenance of Effort."

There was a form put out by HEW entitled "Report of Expenditures." Again "Maintenance of Effort" was referred to. Under the heading "Maintenance of Effort" it was explained that "This is an assurance by the grantee that his financial effort was maintained to support a given health area and that Federal funds did not supplant grantee funds."

None of the instructions or forms were changed after the 1975 amendment. None of the forms or instructions, of course, ever referred to deduction of federal grants by third-party payors.

The same test was incorporated in the Report of the Health Subcommittee of the Committee on Labor and Public Welfare of the United States Senate on the CMHC Services Act, April 1973, under the heading "Maintenance of Effort."

The hospitals were entitled to believe that "Maintenance of Effort" was the test when they made the assurances to the Secretary which they were required to make. In making their assurances, therefore, they would have complied with the instructions and the law, insofar as they could have ascertained it, even if the Secretary had not been fully aware of the custom and practice in Western Pennsylvania.[5]

---

[5]Maintenance of Effort was all the law required. From a reading of the Historical Note at 42 U.S.C. §2688 the Amendment of March 4, 1970 (P.L. 91-211) which added the words "including third-party health insurance payments" was followed by another Amendment of October 30, 1970 (P.L. 91-515) which said that the provisions of §221(a)(4) "shall be deemed to have been complied with for any period after June 30, 1970, if the Secretary determines that there is satisfactory assurance that the total amount of costs... incurred for staffing purposes... will not be less than the amount of such costs for the period which last commenced on or before June 30, 1970."

We conclude that the hospitals may not collect anything from Blue Cross nor can the Secretary collect anything from the hospitals. The Federal grants should continue assuming they are otherwise lawful. The contracts should remain undisturbed until the parties agree to change them and the parties shall each bear their own costs. An order will be made accordingly.

This opinion shall be deemed to include the findings of fact and conclusions of law required by Rule 52.

/s/ BARRON P. McCUNE
Barron P. McCune
United States District Judge

Dated: August 14, 1978
cc: Counsel of record.

IN THE

Supreme Court of the United States

October Term, 1979

No. 79-878

WESTMORELAND HOSPITAL ASSOCIATION, a non-profit corporation, LATROBE AREA HOSPITAL, a non-profit corporation, THE ALTOONA HOSPITAL, a non-profit corporation, THE HAMOT MEDICAL CENTER OF ERIE, PENNSYLVANIA, a non-profit corporation, MEADVILLE CITY HOSPITAL, a non-profit corporation, SAINT VINCENT HEALTH CENTER, a non-profit corporation, COMMUNITY MENTAL HEALTH CENTER OF BEAVER COUNTY, a non-profit corporation, SOUTH HILLS HEALTH SYSTEM, a non-profit corporation, and HENRY CLAY FRICK COMMUNITY HOSPITAL, a non-profit corporation,

Plaintiffs-Petitioners,

v.

BLUE CROSS OF WESTERN PENNSYLVANIA, a non-profit corporation,

Defendant-Respondent.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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42 C.F.R. paragraph 54.302(c) 3, 12, 13, 20, 1a

42 C.F.R. paragraph 54.302(d)(2)(iv) 3, 13, 20, 1a, 2a

42 C.F.R. paragraph 54.305(b) 3, 13, 20, 2a, 3a

42 C.F.R. paragraph 54.306 ..... 3, 13, 20, 3a

[1963] U.S. Code Cong. & Ad. News 10

Restatement of Contracts, Section 247 11

IN THE

Supreme Court of the United States

October Term, 1979

No. 79-878

WESTMORELAND HOSPITAL ASSOCIATION, a non-profit corporation, LATROBE AREA HOSPITAL, a non-profit corporation, THE ALTOONA HOSPITAL, a non-profit corporation, THE HAMOT MEDICAL CENTER OF ERIE, PENNSYLVANIA, a non-profit corporation, MEADVILLE CITY HOSPITAL, a non-profit corporation, SAINT VINCENT HEALTH CENTER, a non-profit corporation, COMMUNITY MENTAL HEALTH CENTER OF BEAVER COUNTY, a non-profit corporation, SOUTH HILLS HEALTH SYSTEM, a non-profit corporation, and HENRY CLAY FRICK COMMUNITY HOSPITAL, a non-profit corporation,

Plaintiffs-Petitioners,

v.

BLUE CROSS OF WESTERN PENNSYLVANIA, a non-profit corporation,

Defendant-Respondent.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Respondent respectfully submits that a Writ Of Certiorari should not issue to review the Judgment Order of the United States Court of Appeals for the Third Circuit entered September 10, 1979.

OPINIONS BELOW

Respondent concurs in Petitioners' statement of the opinions below.

JURISDICTION

Respondent does not question the jurisdiction as set forth in the Petition.

QUESTION PRESENTED

Does the federal statute and public policy pertaining to grants awarded to hospitals to fund staff costs at community mental health centers prohibit the deduction of such grants by a non-profit hospital plan in determining reimbursable costs (i) where the federal statute does not expressly prohibit such deduction, (ii) where the federal regulations defining compliance with the applicable provision of the federal statute were strictly complied with, and (iii) where, under the reimbursement formula in use, the non-profit hospital plan in fact subsidizes the mental health services for which the grants were made?

STATUTE AND REGULATIONS INVOLVED

Respondent does not question the statement of the statute involved as set forth in the Petition. However, it is important to note that certain federal regulations, 42 C.F.R. paragraphs 54.302(c); 54.302(d)(2)(iv); 54.305(b) and 54.306 set forth in Appendix G, *infra,* p. 1a, expressly state the test to be employed in determining compliance with the provision of the statute which is centrally at issue herein.

STATEMENT OF THE CASE

History of the Proceedings

The instant action is before this Court on Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit by nine Plaintiff-Petitioners, all non-profit hospitals in Western Pennsylvania (the "Hospitals" or "Petitioner Hospitals").[1] The Hospitals originally brought suit against Respondent, Blue Cross of Western Pennsylvania, also a non-profit corporation ("Blue Cross"), in the Court of Common Pleas of Westmoreland County, Pennsylvania.

The Hospitals' Complaint sought to enjoin Blue Cross from computing reimbursable costs to the Hospitals in the manner then and now employed by Blue Cross and also sought money damages from Blue Cross

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1. The Hospitals are Westmoreland Hospital Association; Latrobe Area Hospital; The Altoona Hospital; The Hamot Medical Center of Erie, Pennsylvania; Meadville City Hospital; Saint Vincent Health Center; Community Mental Health Center of Beaver County; South Hills Health System; and Henry Clay Frick Community Hospital, all non-profit corporations.

upon the grounds that Blue Cross' deduction of certain federal grants received by the Hospitals in determining reimbursable costs violated the reimbursement contract between the Hospitals and Blue Cross and was contrary to federal law, including directives of the Department of Health, Education and Welfare.

The federal grants at issue (the "Federal Staffing Grants") are funds provided by the federal government "to meet . . . a portion of the costs . . . of professional and technical personnel for the initial operation of new community mental health centers or of new services in community mental health centers." 42 U.S. Section 2688(a). Each Petitioner Hospital received Federal Staffing Grants pursuant to the Community Mental Health Centers Construction Act Amendments of 1965, P.L. 89-105, August 4, 1965, 79 Stat. 427, 42 U.S.C. Section 2688, et seq., as amended by P.L. 90-31, June 24, 1967, 81 Stat. 79; P.L. 91-211, March 13, 1970, 84 Stat. 55; P.L. 91-515, October 30, 1970, 84 Stat. 1297; and P.L. 94-63, July 29, 1975, 89 Stat. 309, 42 U.S.C. Section 2689 et seq. (collectively referred to herein as the "Federal Statute").

The instant action was precipitated when the Department of Health, Education and Welfare ("HEW") notified the Hospitals that they were in violation of a condition attached to the Federal Staffing Grants and that the grants would be discontinued on January 1, 1977 unless the Hospitals persuaded Blue Cross to cease deducting the Federal Staffing Grants in determining allowable costs for Blue Cross reimbursement purposes.

Blue Cross removed the suit, pursuant to 28 U.S.C. Section 1441, et seq., to the United States District Court for the Western District of Pennsylvania upon the

grounds that the Hospitals' Complaint set forth civil causes of action arising under the Federal Statute. The Hospitals filed a Motion to Remand the action to the State Court. The district court denied the Hospitals' Motion to Remand and joined the Secretary of HEW as an indispensable party under Rule 19 of the Federal Rules of Civil Procedure. Subsequently, HEW counterclaimed against eight of the Hospitals seeking to recover for allegedly erroneous grant payments made since the 1975 amendments to the Federal Statute, alleging that the Hospitals had violated an assurance which they were required to make to HEW that the Federal Staffing Grants would be used to supplement state, local and other non-Federal funds and in no event supplant such funds.

A non-jury trial was held beginning on June 15, 1977 and concluding on August 16, 1977. The district court rendered an Opinion and Order on August 14, 1978, which found that Blue Cross properly deducted the Federal Staffing Grants under its contracts with the Hospitals, that Blue Cross' deduction did not violate the Federal Statute or any underlying public policy, and that the Hospitals had not violated their assurances to HEW in receiving the grants. The district court concluded that Blue Cross owed nothing to the Hospitals, that the Hospitals owed nothing to HEW and that HEW should continue to make the Federal Staffing Grants.

The Hospitals and HEW appealed to the United States Court of Appeals for the Third Circuit from the district court's decision. Thereafter, HEW dismissed its appeal. The Court of Appeals concluded that federal jurisdiction was proper and affirmed the judgment of the district court on the merits stating that it had "no

difficulty affirming the judgment of the district court essentially for the reasons set forth in its opinion." (App. D, p. 16a) (Appendix references set forth herein are to the appendices set forth in the Petition for a Writ of Certiorari).

History of Blue Cross Reimbursement of Hospitals

Blue Cross, which came into existence in 1938 as a non-profit corporation, developed in the ensuing years a comprehensive program of pre-paid hospital services and made such services available to the entire Western Pennsylvania community. One of the most important developments of the Blue Cross program is its Participating Hospital Reimbursement Agreement (the "Reimbursement Agreement") under which Blue Cross pays area hospitals directly for services rendered to hospital patients who are Blue Cross subscribers. This new method of payment greatly improved the hospitals' financial positions by providing them with a reliable and regular source of payments for patient services. In addition, Blue Cross offers comprehensive coverage for all segments of the community, including higher risk subscribers, which coverage substantially reduces a participating hospital's bad debt loss. The participating hospitals,[2] including all nine Petitioner Hospitals, in return for these and other benefits agreed to charge Blue Cross their costs attributable to rendering services to Blue Cross subscriber patients rather than charging Blue Cross the hospital's retail charges.

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2. Participating hospitals are defined by the Hospital Reimbursement Agreement as parties thereto. There are over 100 participating hospitals in Western Pennsylvania.

Until 1966, when the Federal Medicare program was enacted and placed in operation, the Blue Cross determination of the amount to be paid to a participating hospital under the Reimbursement Agreement then in effect was based upon a determination of average per diem costs of the participating hospital. However, in 1966 when the Medicare program took effect, Medicare's system of reimbursement for services received by Medicare recipients resulted in hospitals being paid by Medicare an amount which was approximately 4% less than their average costs for services. Responding to the financial dilemma of the participating hospitals created by the Medicare reimbursement gap, Blue Cross in its 1966 Reimbursement Agreement adopted a unique method of reimbursement whereby Blue Cross pays participating hospitals about 4% above their average cost for services provided all Blue Cross patients, thus alleviating the reimbursement gap left by the Medicare system. (App. F, p. 27a, 31a)

The Blue Cross reimbursement formula which has been in effect since the advent of Medicare in 1966 is known as the RCCAC formula (Ratio of Charges-to-Charges Applied to Costs). Under this formula, after Medicare costs have been carved out, the remaining hospital costs are apportioned between inpatient and outpatient costs in the same proportion that the hospital's charges are divided between inpatient and outpatient charges. As the district court found, under the RCCAC formula any reduction in outpatient charges below cost operates to increase inpatient per diem costs and thereby increases Blue Cross' total reimbursement to a participating hospital because of the preponderance of Blue Cross covered inpatient services. As hereinafter discussed, as a result of the Petitioner Hospitals' practices of charging far less than their costs for outpatient men-

tal health services, Blue Cross' total reimbursement to each Petitioner Hospital has greatly increased. In addition, because the Federal Staffing Grants were restricted to new or expanded mental health services, Blue Cross' level of payments to the Petitioner Hospitals significantly increased as a result of their receipt of the Federal Staffing Grants because it was reimbursing costs of new services which had not been incurred before (App. F, p. 34a, 37a).

Irrespective of what formula is used to reimburse hospitals, before applying the formula, Blue Cross must first determine a hospital's costs. This initial cost determination was centrally at issue in this action.

Since 1951, the reimbursable costs of a participating hospital have been established by uniformly applying cost accounting principles developed by Blue Cross in conjunction with and in constant communication with the participating hospitals. One such accounting practice has been the distinguishing between, and treating differently, types of gifts and grants a hospital receives. As a result, gifts, grants and endowments to hospitals have become classified as either "restricted" or "unrestricted". Throughout the entire course of their cost reimbursement history, a restricted gift or grant has been defined and classified by Blue Cross and by the participating hospitals as a gift, grant and/or income from endowments, the proceeds of which must be used only for a specific purpose designated by the donor thereof.[3]

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3. The deduction of restricted grants in determining cost reimbursement is consistent with generally accepted accounting principles and has been endorsed by the American Hospital Association, the Commonwealth of Pennsylvania for Medicaid purposes and by HEW for Medicare purposes. (App. F, p. 28a).

Restricted grants and gifts have been consistently deducted from the amount of a participating hospital's costs in determining such hospital's "allowable costs" for Blue Cross reimbursement purposes.[4] The rationale for deducting a restricted grant from costs is to maintain a principle of reimbursement basic to the community and to the Reimbursement Agreement that a hospital should only be reimbursed for its reasonable costs, and that if a specific item of cost has already been paid for it should not again be the basis for reimbursement.

When the Hospitals began receiving the Federal Staffing Grants, Blue Cross deducted the amount of the grants from each Hospital's costs as a restricted grant pursuant to the Reimbursement Agreement, because the Federal Staffing Grant was specifically limited by the terms of the Federal Statute to be used only to pay staff salaries in a Hospital's community mental health center.[5]

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4. Blue Cross' 1973 Reimbursement Agreement, currently in effect, provides that the reimbursement formula is applied to a hospital's "allowable costs".

5. The district court found that the practice of deducting restricted grants in determining reimbursable costs was an operative term under the applicable Reimbursement Agreements even though the Reimbursement Agreements do not mention restricted grants as such (App. F, p. 26a). See *United Mercury Mines Co. v. Bradley Mining Co.*, 259 F.2d 845 (9th Cir. 1958); *Edward E. Morgan Co. v. United States*, 230 F.2d 896 (5th Cir. 1956); *Pacific Grape Prod. Co. v. Commissioner of Internal Revenue*, 219 F.2d 862 (9th Cir. 1955); *Wilson v. Homestead Valve Mfgr. Co.*, 217 F.2d 792 (3d Cir. 1954); *John I. Haas, Inc. v. Wellman*, 186 F.2d 862 (9th Cir. 1951); *Tennessee Gas & Transmission Co. v. El Paso Natural Gas Co.*, 166 F.2d 9 (5th Cir. 1948); *McKeefrey v. Connellsville Coke & Iron Co.*, 56 F. 212 (3d Cir. 1893); *Electric Reduction Co. v. Colonial Steel Co.*, 276 Pa. 181 (1923); *Fiske v. First Nat. Bank of Butte,*

History of the Federal Staffing Grants

The relevant history of the Federal Statute authorizing the Federal Staffing Grants commenced in 1963 when Congress enacted P.L. 88-164 entitled the "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963", 42 U.S.C. Section 2661 et seq., which provided funds for new building facilities if states developed comprehensive mental health plans which would make mental health care available in local communities. In 1965, Congress enacted P.L. 89-105 entitled the "Community Mental Health Centers Construction Act Amendments" which authorized the Secretary of HEW to make:

> "grants to meet, for the temporary periods specified in this Section, a portion of the costs (determined pursuant to regulations under Section 2688c of this title) of compensation of professional and technical personnel for the initial operation of new community mental health centers or of new services in community mental health centers." 42 U.S.C. Section 2688(a).

Such Federal Staffing Grants were authorized on a decreasing matching basis to finance a portion of the eligible staffing costs of a community mental health center ("CMHC"). There is no question that the object of the Federal Statute was to sponsor a system of local mental health facilities to provide certain "essential" mental health services, specified in the Federal Statute,

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133 Pa. 241 (1890); *Adams v. Pittsburgh Ins. Co.*, 95 Pa. 348 (1880); *Carter v. Philadelphia Coal Co.*, 77 Pa. 286 (1875); *Fischer v. Congregation B'Nai Yitzhok*, 177 Pa. Super. 359 (1955); *Stenden v. Twin City Foods, Inc.*, 510 P.2d 221 (Wash. 1973); *Restatement of Contracts*, Section 247.

on a community basis to generally replace "the outmoded type of institutional care which now prevails".[6] However, as admitted by HEW in the case at bar, "nothing is contained in the federal statute which would indicate that it is intended to control the activities of this Blue Cross plan or any other third-party payor in applying a reimbursement formula." (App. F., p. 31a).

Centrally at issue in the instant action is the provision of the Federal Statute (the "supplement not supplant" provision) which required the Hospitals, as potential Federal Staffing Grant recipients, to give assurance to HEW that the Federal Staffing Grants would not supplant "State, local and other non-Federal funds". P.L. 89-105, Section 221(a)(4), 42 U.S.C. Section 2688a(a)(4).[7] The sanction set forth in the Federal Statute for a CMHC's failure to comply with such assurance was the loss of the Federal Staffing Grant. There is no mention of the invalidation of reimburse-

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6. [1963] U.S. Code Cong. & Ad. News, p. 1469.

7. Under the 1975 amendments to the Federal Statute, Section 206 (c) (2) (B) (ii) of P.L. 94-63, 42 U.S.C. Section 2689e, the Secretary of HEW could approve an application for a grant only if he determines that the application contains or is supported by satisfactory assurances that federal funds made available thereunder will "be used to supplement and, to the extent practical, increase the level of State, local and other non-Federal funds, including third-party health insurance payments, that would in the absence of such Federal funds be made available for the applicants' comprehensive mental health services and (II) in no event supplant such State, local and other non-Federal funds." The language of 42 U.S.C. Section 2689e is substantially the same as 42 U.S.C. Section 2688a which was in effect prior to the 1975 amendments.

ment agreements with third party payors such as Blue Cross.

The Hospitals applied for and received Federal Staffing Grants at various times since 1969. In all relevant grant years each Hospital gave such assurance to HEW. During such period, because the Federal Staffing Grants fit exactly within the definition of a restricted grant under the Reimbursement Agreement, Blue Cross consistently treated the Federal Staffing Grants as a deduction from costs in determining the Hospitals' reimbursable Blue Cross costs.

The district court's decision that Blue Cross' deduction of the Federal Staffing Grants in determining the Hospitals' reimbursable costs (i) is not illegal or opposed to public policy (App. F., p. 33a), and (ii) has not caused the Hospitals to violate the "supplement not supplant" assurance (App. F., p. 41a) was based in part on its finding that each Hospital had complied with a "Maintenance of Effort" test set forth in the Federal Regulations.

42 C.F.R. paragraph 54.302(c) adopted on March 1, 1966, and still in effect, provides that compliance with a "Maintenance of Effort" test "shall be deemed to constitute" a satisfactory assurance that the "supplement not supplant" provision of the Federal Statute has not been violated. 42 C.F.R. paragraph 54.302(c) states:

> "For purposes of section 221(a)(4) of the Act, with respect to assurance that Federal funds will not supplant non-Federal funds, budget information meeting the requirements of Section 54.305(b) sufficient to support a grant under Section 54.306, together with information providing an adequate basis for a determination by the Surgeon General under paragraph (d)(2)(iv) of this section that there has not been a decline in State financial support, shall be deemed to constitute such satisfactory assurance . . . ."

The test referred to in 42 C.F.R. paragraph 54.302 (c) is that budget information must be supplied showing (i) that in the year for which a Federal Staffing Grant is requested, the CMHC's total expenditures for mental health services will exceed its average expenditures therefor during the two-year period preceding the CMHC's initial receipt of a Federal Staffing Grant, 42 C.F.R. paragraphs 54.305(b) and 54.306, and (ii) that the amount expended by the state for mental health purposes in such calendar year will not decline from the amount expended by the state therefor in either of the two preceding calendar years, 42 C.F.R. paragraph 54.302(d)(2)(iv).

Not only do the Federal Regulations set forth the sole test for compliance with the "supplement not supplant" provision of the Federal Statute, the CMHC instructional materials and budget information compliance forms distributed by HEW also state that the "Maintenance of Effort" test determines compliance with "supplement not supplant" provision of the Federal Statute.

HEW was on notice that Blue Cross was deducting the Federal Staffing Grant as early as 1969, but did not act to cancel the grants until late in 1976. (App. F, p. 27a). Medicare, which has a different cost reimbursement system than Blue Cross', deducted the Federal Staffing Grants as restricted grants for approximately

six years until a "seed money" exception was added to the Medicare reimbursement practices in 1971.[8]

In 1969, when HEW was notified that the State of Pennsylvania deducted the Federal Staffing Grants in determining allowable costs for mental health reimbursement purposes, HEW responded as follows:

> The matter of how the state views the federal matching money (as part of the 90% eligible for their participation or otherwise) is entirely up to them .... We are quite aware that the staffing grant, during the four years of its existence in a sense replaces state money, but more to the point it provides the means to share the financial burden for the initial period so the state has lead time for planning and getting ready to assume the full cost of services." (Defendant's Exhibit C).

In response to an interrogatory propounded by Blue Cross to HEW as to why it continued to make the Federal Staffing Grants in Michigan for a number of years after learning that the grants were being deducted by Blue Cross of Michigan in determining reimbursable costs, HEW stated that the Secretary was awaiting "the ascertaining of a national policy by the National Institute of Mental Health on such matter" (App. F., p. 33a).

The district court therefore found "the Secretary [of HEW], until this litigation, has never had a policy on this issue and has never contended that deduction of the

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8. Blue Cross is in no way obligated to follow the Medicare reimbursement system in computing Blue Cross' reimbursement. (App. F., p. 30a).

grants is opposed to the law or public policy." (App. F., p. 33a)

As set forth hereinabove, under Blue Cross, reimbursement formula, a reduction in a hospital's outpatient charges below cost operates to increase the hospital's inpatient costs and thereby increases Blue Cross' total reimbursement to the hospital because of the preponderance of Blue Cross covered inpatient services. The evidence of record in the instant action shows that each Hospital's outpatient mental health costs substantially exceeded its outpatient mental health charges (App. F., p. 36a-38a). Because the CMHC services were required by the Federal Statute to be new services and caused each Hospital to incur additional costs, and since the effect of the Hospitals' practice of undercharging for outpatient mental health services grossly inflated Blue Cross' reimbursements to the Hospitals, the district court concluded that Blue Cross has in fact been subsidizing the Hospitals' mental health programs even though it deducts the Federal Staffing Grants in determining Blue Cross reimbursement. (App. F., p. 34a, 37a).

In summary (i) the Federal Statute does not purport to control the reimbursement practices of a third party payor such as Blue Cross or in any way prohibit the deduction of the Federal Staffing Grants in computing cost reimbursement; (ii) the Federal Regulations and HEW's instructional materials expressly set forth the sole test for determining compliance with the "supplement not supplant" provision of the Federal Statute; (iii) each Petitioner Hospital complied with such test even though Blue Cross deducted the Federal Staffing Grants in computing Blue Cross' reimbursement; and

(iv) under Blue Cross' reimbursement formula, the Hospitals' practice of charging below cost for outpatient mental health services has caused Blue Cross to subsidize the Hospitals' mental health programs even though Blue Cross deducted the Federal Staffing Grants in determining reimbursable costs.

REASONS FOR DENYING THE WRIT

1. The Petitioner Hospitals argue in each point of their "Reasons For Granting the Writ" that Blue Cross' deduction of the Federal Staffing Grant in determining cost reimbursement contravenes both the "supplement not supplant" provision of the Federal Statute and the public policy underlying the Federal Statute, and assert that such deduction has harmed the Hospitals and the public because the effect thereof is that the Hospitals receive less Blue Cross reimbursements than they would have if the Federal Staffing Grant were not deducted. However, there is no foundation in the record for such argument because the district court found that the Hospitals failed to sustain their burden of proof that Blue Cross' deduction results in the supplanting of private funds by the Federal Staffing Grant.[9] This finding of fact has not been challenged by the Hospitals.

It is submitted that the district court carefully scrutinized the effect of Blue Cross' deduction of the Federal Staffing Grants and the overall effect of Blue Cross' Reimbursement Agreement on reimbursements to each of the Hospitals and properly determined that no supplanation has occurred and that no harm has resulted to the Hospitals' mental health programs as a result thereof. To the contrary, the district court found that under Blue Cross' reimbursement formula the fact that the Hospitals' outpatient mental health costs far exceeded the Hospitals' charges for outpatient mental health services resulted in Blue Cross "subsidizing the

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9. "I am not convinced by a preponderance of the evidence that there has been any supplanting of private money by the federal grants as a matter of fact." (App. F., p. 38)

Mental Health Programs to a large extent" (App. F., p. 37a).

Since the district court refused to find as a matter of fact that Blue Cross' deduction of the Federal Staffing Grants results in supplantation or in any lessening of Blue Cross' obligations to the Hospitals, there is simply no factual basis in the instant action to support the Hospitals' argument that the public policy underlying the Federal Statute has been violated by virtue of Blue Cross receiving a "substantial benefit from the grant money to the detriment of the mental health program."[10] Because the Hospitals' "Reasons for Granting the Writ" necessarily depend upon a factual determination which the district court refused to make, the hospitals' Petition for a Writ of Certiorari should be denied. This Court does not grant a certiorari to review evidence and discuss specific facts, *United States v. Johnston,* 268 U.S. 220, at 227 (1925).

2. Although the instant case is one of first impression insofar as the Federal Statute is concerned, the consequences hereof are hardly "far flung" as contended by the Hospitals. Apparently HEW does not believe that the consequences of the district court's decision are "far flung" because HEW has not appealed from the denial of its counterclaim herein.

The district court carefully scrutinized the overall effect of Blue Cross' reimbursement formula on each Hospital, including the deduction of the Federal Staffing Grants, and found that Blue Cross' reimbursement con-

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10. On the merits the Third Circuit Court of Appeals had "no difficulty affirming the judgment of the district court essentially for the reasons set forth in its opinion. . . ." (App. D., p. 16a)

tract is unique (App. F, p. 27a) and that as a result of Blue Cross' unique contract "Blue Cross subscribers have been subsidizing a good portion of the costs of the mental health programs thus far". (App. F, p. 34a) Necessarily, the applicability of the decision on the merits of the instant case to other Blue Cross plans and other CHMCs is dependent on whether the factual situation presented would be similar to that in this case in regard to, inter alia, the ability of the Hospitals to unilaterally increase their Blue Cross reimbursements by undercharging for outpatient mental health services.

Even if a similar factual and contract setting were presented in a reimbursement dispute between a CMHC and a third party payor, the district court's decision herein would not have an adverse impact upon the CMHC or the patients it serves because the district court correctly concluded that Blue Cross' deduction of the Federal Staffing Grant does not result in supplantation and is permissable under the Reimbursement Agreement.

3. It is respectfully submitted that the instant action presents neither (i) a situation where a lower court has decided a federal question in a way in conflict with the applicable decisions of this Court, nor (ii) an important federal question which has not been, but should be, settled by this Court. The district court properly concluded that neither the Federal Statute, the regulations promulgated thereunder nor any underlying public policy renders Blue Cross' reimbursement practice void.

The "supplement not supplant" provision of the Federal Statute, as admitted by HEW, does not control the reimbursement practices of a third party payor such as Blue Cross (App. F., p. 31a), but is an assur-

ance which CMHCs must give to HEW to qualify for the Federal Staffing Grants. The sanction set forth in the Federal Statute for a CMHC's non-compliance with such assurance is the loss of the Federal Staffing Grant, not the invalidation of reimbursement agreements with third party payors.

Furthermore, the regulations promulgated by HEW expressly set forth a test, referred to as a "Maintenance of Effort" test, for determining compliance with the "supplement not supplant" provisions. The regulations provide that a CMHC has complied with its assurance if it shows that (i) in the fiscal year when the Federal Staffing Grant is received the CMHC's total expenditures for mental health services exceeds its average expenditures therefor during the two-year period preceding its initial grant period; and (ii) the amount expended by the State for mental health services during such year will not decline from the amount expended in either of the two preceding years. 42 C.F.R. paragraphs 54.302(c); 54.302(d)(2)(iv); 54.305(b); 54.306.[11]

There is no dispute that each Hospital complied with the "Maintenance of Effort" test for all relevant grant years. Clearly the "Maintenance of Effort" test

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11. Congress endorsed a "Maintenance of Effort" test for determining compliance with the "supplement not supplant" provision of the Federal Statute, when it enacted an amendment to the Federal Statute on October 30, 1970, P.L. 91-515, Title III, Section 301, which amendment provided that for CMHCs which received a Federal Staffing Grant before June 30, 1970, the "supplement not supplant" assurance "shall be deemed to have been complied with" for any period after June 30, 1970 if the CMHC's total mental health staff costs are not less than its costs for the grant period which last commenced on or before June 30, 1970.

has no bearing whatsoever on Blue Cross' reimbursement formula. It is important to note that the Hospitals have not appealed the district court's finding that the "supplement not supplant" provision of the Federal Statute has not been violated by virtue of the Hospitals complying with the "Maintenance of Effort" test.

The district court did not restrict its public policy analysis to just the Federal Statute and applicable regulations. The district court analyzed CMHC instruction manuals and CMHC report of expenditure forms distributed by HEW, all of which state that compliance with the "Maintenance of Effort" test constitutes compliance with the "supplement not supplant" requirement. Moreover, the district court properly found that "the Secretary [of HEW], until this litigation, has never had a policy on this issue and has never contended that deduction of the grants is opposed to the law or public policy" (App. F., p. 33a). Such finding was based in part upon the fact, noted above, that HEW, in response to an interrogatory concerning the reason it continued to make the Federal Staffing Grants when it was aware of the deduction thereof for cost reimbursement purposes, stated that it did so because the Secretary of HEW was awaiting "the ascertaining of a national policy by the National Institute of Mental Health on such matter." (App. F., p. 33a).

Since neither the Federal Statute, the regulations promulgated thereunder, nor any of HEW's CMHC forms make any mention of the deduction of the Federal Staffing Grants for cost reimbursement purposes, this Court's decision in *Muschany v. United States,* 324 U.S. 49 (1945) directly supports the district court's decision that Blue Cross' reimbursement practice violates neither

the Federal Statute nor the public policy underlying the Federal Statute. As this Court stated in *Muschany* at 66:

> "As the term 'public policy' is vague, there must be found definite indications in the law of the sovereignty to justify the invalidation of a contract as contrary to that policy. . . . Only dominant public policy would justify such action. In the absence of a plain indication of that policy through long governmental practice or statutory enactments, or of violations of obvious ethical or moral standards, this Court should not assume to declare contracts . . . contrary to public policy." (citation omitted)

This Court's decision in *Steele v. Drummond,* 275 U.S. 199 (1927), relied upon by the Hospitals in their "Reasons for Granting the Writ", did not deal with the issue of whether a contract is void as contrary to "public policy" as established by a legislative enactment. However, this Court clearly recognized in *Steele v. Drummond* that, with respect to invalidating contracts as being contrary to public policy,

> "It is a matter of great public concern that freedom of contract be not lightly interfered with. . . . It is only in clear cases that contracts will be held void." 275 U.S. at 205.

The Hospitals' Petition for a Writ of Certiorari does not mention the aforesaid Federal Regulations, HEW's CMHC instruction materials, or the 1970 amendment to the Federal Statute, all of which expressly state that the "supplement not supplant" requirement is met if a "Maintenance of Effort" test has been satisfied. Instead, the Hospitals argue that vague, general expressions of the purpose of the Federal Statute, which do not

deal with third party payor *cost* reimbursement at all and which are not contained in the Federal Statute, should have been relied upon to invalidate Blue Cross' reimbursement practice. Thus, the Hospitals' public policy argument violates the rule established by this Court in *Muschany v. United States, supra,* at 66, that "Public Policy is to be ascertained by reference to the laws and legal precedents and not from general considerations of supposed public interests."

Because the district court followed the directions of this Court in *Muschany v. United States, supra,* in concluding that Blue Cross' deduction of the Federal Staffing Grant does not violate the Federal Statute or the public policy underlying the Federal Statute, and because this Court's opinion in *Muschany* controls the issue of when a contract will be held invalid as contrary to public policy as established by a Congressional enactment, the instant action presents neither (i) a situation where a lower court has decided a federal question in a way in conflict with the applicable decisions of this Court, nor (ii) an important federal question which has not been, but should be, settled by this Court.

Conclusion.

CONCLUSION

For the foregoing reasons it is respectfully requested that the Petitioner Hospitals' Petition for a Writ of Certiorari be denied.

Respectfully submitted,

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APPENDIX G

42 Code of Federal Regulations

(as of October 1, 1975)

SUBPART D—GRANTS FOR INITIAL COST OF PROFESSIONAL AND TECHNICAL PERSONNEL OF COMMUNITY MENTAL HEALTH CENTERS

PARAGRAPH 54.302. ELIGIBLE CENTERS.

To be eligible for a grant to assist in the initial operation of a community mental health center under Part B of Title II of the Act the application must be in accordance with, and set forth the assurances and information required by, Section 221(a) of the Act and Section 54.305.

. . . .

(c) For purposes of section 221(a)(4) of the Act, with respect to assurance that Federal funds will not supplant non-Federal funds, budget information meeting the requirements of Section 54.305(b) sufficient to support a grant under Section 54.306, together with information providing an adequate basis for a determination by the Surgeon General under paragraph (d)(2)(iv) of this section that there has not been a decline in State financial support, shall be deemed to constitute such satisfactory assurance; Provided, That in determining whether there has been a decline in the proportion of public funds of the State in relation to the total funds expended in the State for mental health services as provided in paragraph (d)(2)(iv) of this section, the Surgeon General may, if he finds in a particular case that such action is consistent with section 221(a)(4) of the Act, disregard funds from private sources.

(d) In addition to describing the services to be provided by the center in the State mental health plan in

accordance with section 221(a)(5) of the Act the State mental health authority shall submit to the Surgeon General:

. . . .

(2) Such additional information as the Surgeon General may require in order to show: (i) Prospective developments in mental health manpower resources throughout the State, (ii) current and proposed efforts to meet statewide needs for such resources, (iii) a ranking of the areas of the State (according to the same geographical division as under Section 54.204 of Subpart C of this part) in order of their ability to meet their need for such manpower, (iv) the amount of funds derived from public revenues of the State expended or estimated to be expended during the current calendar year and the 2 preceding calendar years to provide public and private nonprofit mental health services for the population of the State, sufficiently documented to enable the Surgeon General to determine that the amount expended or estimated to be expended by the State for such purposes during such current year has not declined or will not decline either on a per capita basis or in proportion to the total amount expended in the State for such services from all sources, from the amount expended in either of such 2 preceding years.

PARAGRAPH 54.305. SUBMITTAL OF APPLICATION.

Each application for assistance under Part B of Title II of the Act shall be submitted to the Surgeon General, and a copy of such application shall be submitted to the mental health authority of the applicant's State responsible for submittal of plans in accordance with Title III of the Public Health Service Act, as

amended. Such application shall, in addition to any other information or assurances found necessary by the Surgeon General to act on the application, set forth the program for all community mental health services provided by the applicant or those affiliated with the applicant, including specific and detailed information and adequate assurances as to the following in such detail and in such form as may be prescribed by the Surgeon General:

. . . .

(b) *Budget.* (1) A statement for each of the two 12-month periods preceding the period for which an initial grant is requested, and an estimate for each period for which a grant is requested, of costs and income incurred or to be incurred by the applicant, affiliates and predecessors of the applicant with respect to all services included in the program set forth under paragraph (a) of this section; . . . .

PARAGRAPH 54.306. APPROVAL OF APPLICATION.

The Surgeon General may approve an application for Federal participation up to the maximum percentage (specified in section 220(b) of Title II of the Act) of eligible costs in excess of the average amount determined or estimated in such application to have been expended for mental health services by the applicant, affiliates, and predecessors of the applicant in the 2 years preceding the initial grant period for which application is made, where such application meets the eligibility requirements specified in Sections 54.302 and 54.303 and the allocation and priority requirements of Section 54.304.

In the Supreme Court of the United States

October Term, 1979

No. 79-878

WESTMORELAND HOSPITAL ASSOCIATION, a non-profit corporation, LATROBE AREA HOSPITAL, a non-profit corporation, THE ALTOONA HOSPITAL, a non-profit corporation, THE HAMOT MEDICAL CENTER OF ERIE, PENNSYLVANIA, a non-profit corporation, MEADVILLE CITY HOSPITAL, a non-profit corporation, SAINT VINCENT HEALTH CENTER, a non-profit corporation, COMMUNITY MENTAL HEALTH CENTER OF BEAVER COUNTY, a non-profit corporation, SOUTH HILLS HEALTH SYSTEM, a non-profit corporation, and HENRY CLAY FRICK COMMUNITY HOSPITAL, a non-profit corporation,

Plaintiffs-Petitioners,

v.

BLUE CROSS OF WESTERN PENNSYLVANIA, a non-profit corporation,

Defendant-Respondent.

Petitioners' Reply To Respondent's Brief In Opposition To The Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

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PETITIONERS' REPLY TO RESPONDENT'S REASONS FOR DENYING THE WRIT

At page 15 of its Brief In Opposition to Petitioner-Hospitals' Petition for a Writ of *Certiorari*, Respondent (hereinafter "Blue Cross") summarized its contentions as follows:

> "...(i) the Federal Statute does not purport to control the reimbursement practices of a third party payor such as Blue Cross or in any way prohibit the deduction of the Federal Staffing Grants in computing cost reimbursement; (ii) the Federal Regulations and HEW's instructional materials expressly set forth the sole test for determining compliance with the 'supplement not supplant' provision of the Federal Statute; (iii) each Petitioner Hospital complied with such test even though Blue Cross deducted the Federal Staffing Grants in computing Blue Cross' reimbursement; and (iv) under Blue Cross' reimbursement formula, the Hospitals' practice of charging below cost for outpatient mental health services has caused Blue Cross to subsidize the Hospitals' mental health programs even though Blue Cross deducted the Federal Staffing Grants in determining reimbursable costs."

Of the foregoing contentions, it is believed that only (ii), (iii) and (iv) merit reply for the reason these contentions are not discussed in the Hospitals' Petition and the contentions confuse or obscure the real issue which the Hospitals seek to have reviewed.

Blue Cross's contentions (ii) and (iii), that the federal regulations and HEW instructional materials set forth in 42 C.F.R. ¶54.302(c)[1] comprise the *sole* test for determining compliance with the "supplement not supplant" provision of

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[1]See Blue Cross's Brief in Opposition, App. G, page 1a.

the federal statute, 42 U.S.C. §2688,[2] and that no supplanting has occurred, are irrelevant. The District Court correctly recognized the inapplicability of the regulation to Blue Cross by stating, at page 33a of the Hospitals' Petition, "The CMHC Policy and Standards Manual and the Federal Regulations, 42 C.F.R. ¶54.302(c), make no reference to the deduction of staffing grants by third party payors." Paragraph 54.302(c) only provides the test (referred to as the "maintenance of effort" test) to determine whether there is or has been a "decline in State financial support" of mental health services. An examination of the regulation provides no support for Blue Cross's argument that if state financial aid to a hospital does not decline, *ergo*, Blue Cross's practice of deducting federal funds does not violate Section 2688. Blue Cross's argument simply does not follow.

Section 2688 speaks not only to the requirement that state and local funds not supplant federal funds, but that the federal funds *supplement* state, local and non-federal funds, "including third party health insurance payments." Hence, paragraph 54.302(c) assures that there will be no decline in the amount of financial support from a state government. However, compliance with the regulation by a state government cannot possibly cure a deviation from Section 2688 by an independent private health insurer. The District Court did not conclude, as indeed it could not, that the Hospitals' ordinary funds would be supplemented if Blue Cross could deduct the federal funds. The flaw in that argument should be apparent. To absolve a private health insurer like Blue Cross from its reimbursement obligation because of benefits received by a hospital from a state government—or from any other party—would be analagous to absolving a tortfeasor from liability for damages because the injured person has received compensation from a third party. This argument has long been rejected. The financial aid a hospital receives from a state government should not inure to the economic benefit of a third-party health insurer, and the expression of this Congressional policy is believed crystal clear in Section 2688.

[2]See Hospitals' Petition, App. B, page 3a.

In any event, assuming state aid does not decline, the test that federal grants *supplement* other funds can never be met by a third-party health insurer when its payments are less than they would otherwise be by virtue of its deduction of the grants, regardless of the grantee's success in raising funds from other sources. Thus, the Hospitals' compliance with the test of Paragraph 54.302(c) pertaining to state aid has no bearing on a violation of Section 2688 by a private health insurer.

Blue Cross's contention(iv), that it has subsidized the hospitals' mental health program even though it has deducted the grants, is likewise fallacious and irrelevant.[3] The argument is bottomed on the admitted fact that in some cases the gross income from the operations of a particular department within a hospital may be less than that hospital's actual cost of operations for that department. That loss, hopefully, is made up by a surplus produced by other departments. This is true not only of hospitals, but of any business. Some departments or products may be more costly or less profitable than others. However, it is the performance of the company as a whole that determines its profitability. However, hospitals are unlike other businesses in at least one

[3]The District Court at 35a-36a of the Petition refers to a letter signed by Sister Margaret Ann Hardner of Saint Vincent Health Center as proof that Blue Cross subsidized the Hospitals' mental health programs. However, at trial it was shown that the letter was not written by Sister Margaret Ann Hardner but by Mr. Robert Cox, Treasurer of Saint Vincent's, who explained that he was merely stating *Blue Cross's* argument (See pages 1436a-1453a of the Appendix filed in the Court of Appeals). With all due respect to the District Court, the Hospitals believe that the District Court misinterpreted the letter.

very important respect. Whereas a run-for-profit business is free to sell, phase out or otherwise rid itself of an unprofitable element of its business, hospitals are not free to operate on a profit-maximizing philosophy. Hospitals are non-profit—the medical needs of the community must be met even though any one service may not be as profitable as another.

A hospital's alternatives are thus: (1) to make unprofitable departments profitable by raising the amounts charged to patients who utilize the less profitable services, even if this sends medical costs spiralling, perhaps beyond the ability of patients to pay; or (2) to cease offering the unprofitable services altogether. This is precisely the dilemma Congress sought to avoid when it voted to establish a program of funding for community mental health centers.

Furthermore, even if Blue Cross is indirectly "subsidizing" unprofitable hospital services in some instances, it has not been singled out. All patients receiving these services are charged the same rate—both those covered by Blue Cross and those not covered. Indeed, Blue Cross even receives a "break" from the Hospitals on its payments. By contract, Blue Cross is protected from being required to pay excessive sums for services to its subscribers, since its maximum liability is limited either to the Hospitals' regular charges for services to patients or to a *per diem* rate based upon cost reimbursement, whichever is less. If Blue Cross elects to pay regular charges for its subscribers, it could, in fact, take advantage for its subscribers of the alleged undercharging in mental health departments and it would pay no more for services in other departments than other insured or uninsured persons. Thus, Blue Cross could settle with the hospitals without regard to the profit or loss from the operation of a community mental health center. Since Blue Cross obviously elects the least costly method of payment, its election to pay on the basis of cost reimbursement rather than on the basis of regular charges refutes any assertion that it subsidizes the mental health programs.

Ironically, the Blue Cross practice of applying federal grants as an offset against reimbursable costs results in Blue Cross being subsidized by the federal government. The Blue Cross cost reimbursement agreement (even without deducting federal grants) regularly results in a savings to Blue Cross of 10 to 20% of the charges paid by other private health insurers or uninsured persons.

The subsidy to Blue Cross by deducting the grants is illustrated by the situation of Community Mental Health Center of Beaver County. Beaver was opened January 1970. The clinic was built through funds available under the community mental health center legislation and it received the benefits of the staffing grant phase of the program beginning in September 1970. The Medical Center of Beaver County (formerly Rochester General Hospital) had signed a charter with the Beaver County Mental Hygiene Clinic to sponsor it for such funding, but it also had a separate charter as a free-standing clinic.

Beaver signed the 1966 Blue Cross contract in March 1970, and the contract took effect retroactively to January 1970. Based on information supplied to Blue Cross by the mental health center officers, a *per diem* rate of $41.12 to cover costs was initially established. Blue Cross gave no indication at this point that it intended to deduct the mental health staffing grants (see page 601a of the Appendix filed in the Court of Appeals). However, at the end of the fiscal year 1970-71, Blue Cross deducted the mental health staffing grant and reduced Beaver's *per diem* rate to $27.53 or $13.59 below cost because of the grants. Thus, a share of the grant flowed to Blue Cross.

Further, it is the fact that for every one dollar saved by cost reimbursement payors, such as Blue Cross, its competitors and uninsured persons are likely to pay an additional four dollars. Since the cost reimbursement agreements do not provide the margin of operating revenue actually required by the Hospitals, Blue Cross's competitors and uninsured persons must take up the slack left by the minimum costs paid by Blue Cross, Medicare and Medicaid.

(See pages 792a-797a of the Appendix filed in the Court of Appeals.)

Thus, in truth, Blue Cross's competitors and uninsured patients must pay more because Blue Cross pays less; and, if any persons subsidize health care, it is Blue Cross's competitors and uninsured patients and not Blue Cross.

CONCLUSION

The contentions of Blue Cross simply do not address the basic issue: whether any agreement, scheme or device to divert the benefits provided by Congress for the mental health program, is void as contrary to the clearly enunciated policy that federal grants are to *supplement* non-federal funds. Petitioner Hospitals respectfully request that this Court accept jurisdiction of this case to review the rulings of the Court of Appeals and the District Court, since these rulings conflict with an important Congressional program.

Respectfully submitted,

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